

UNIVERSITY OF ALBERTA

THE VIABILITY OF THE PRIMARY HEALTH CARE MODEL
FOR WOMEN'S HEALTH: AN ETHNOGRAPHIC STUDY OF WOMEN'S HEALTH
BELIEFS, VALUES, AND PRACTISES IN RURAL VANUATU

BY
DONNA-MAE FORD ©

A thesis submitted to the Faculty of Graduate Studies and
Research in partial fulfillment of the requirements for the
degree of MASTER OF EDUCATION.

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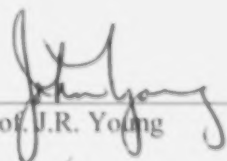
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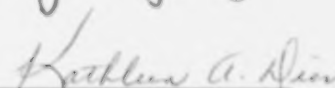
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The undersigned certify that they have read and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "The Viability of the Primary Health Care Model for Women's Health; An Ethnographic Study of Women's Health Beliefs, Values, and Practices in Rural Vanuatu" submitted by Donna-Mae Ford in partial fulfillment of the requirements for the degree of Master of Education in Sociology of Education.


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ABSTRACT

Despite the fact that since 1978 PHC has been accepted, in most countries of the world, as an official guide for health policy planning, little research has focused on the relationship between the premises and assumptions on which the model is based and the beliefs and values which frame the health perspectives of indigenous groups - much less those of indigenous women. In this study, the researcher uses an ethnographic methodology to develop a detailed account of the health beliefs, values, preferences, and practices of a group of rural Ni-Vanuatu women. This account describes: the extent to which improving health is a goal or priority for them; their perceived health status, health needs, and health priorities; the types of health interventions they currently use and the etiological beliefs undergirding them; and their beliefs about the ways and means through which health improves. This account is then placed along side the PHC model so that a comparison can take place and ultimately an evaluation of the viability of the PHC model in this context. What evolves is essentially a feminist critique of PHC, one which underlines the extent to which the health issues identified by these women are rooted in the social and cultural fabric of their society and ultimately in their subordinate social position. The researcher concludes that the PHC model is limited by its failure to adequately *situate* women's health problems in the context of social relationships, more particularly in the context of gender relations. The sociology of knowledge provides a some analytical tools for speculating about how and why this may be the case.

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CHAPTER 1

INTRODUCTION AND OVERVIEW

This study evolved from an interest in examining the "interface" of different world views or paradigms as they pertain to health and health problems. Those who have been involved in development initiatives at the "grass-roots" level, particularly in developing contexts, will be aware that there is continuous translation and transmutation process that goes on between indigenous beliefs, values, and orientations and those ideas, approaches, and innovations which are brought in from time to time from the outside world. Large technical development agencies, which frequently devise new frameworks and strategies for improving health, have considerable influence as their health agendas filter down from the level of international conferences, to governments, ministries of health, and then to the local level where they are translated and operationalized. For various reasons, not the least of which is their ability to provide funding, the strategies and approaches which they promote carry enormous weight. While it is true that such agencies often provide valuable expertise and resources for improving the health of people in the developing world, they also define and circumscribe "problems", and sanction "effective" and "appropriate" interventions, and in doing so, inadvertently marginalize alternate interpretations of health phenomena and alternate approaches and interventions.

In 1978, WHO declared PHC (Primary Health Care) to be the vehicle through which "Health for All" was to be achieved. Since that time more than 150 governments have accepted PHC as official policy for health planning (Rifkin and Walt 1986) and non-government organizations as well have been diligent to make it the focus of their various health endeavors. In contrast to more conventional health-care approaches, PHC represents a relatively progressive and emancipatory innovation with its emphasis on self-reliance, community participation, health education, and prevention. But it would be naive to simply assume that the assumptions and values it embodies and the objectives and methods it promotes as essential to improving health will resonate as viable or true for everyone, particularly for those who have not been acculturated or educated into dominant perspectives on health and development. This study represents an attempt to investigate this query, more specifically to examine the "fit" between the PHC model and the health perspective of a group of women in rural Vanuatu.

Using an ethnographic methodology, the researcher has elicited information from Ni-Vanuatu women around four broadly delineated guiding questions. These questions focus on: 1) the extent to which improving health is a priority or goal for them 2) their everyday health problems and health priorities 3) their current health practices and the

etiological beliefs underlying them and 4) their beliefs regarding the means through which health improves. The information collected around these questions provides a comprehensive and holistic picture against which to evaluate the extent to which the PHC model, more specifically some of the assumptions on which it is based, "fits" in this context. It also provides a springboard for considering the socio-structural nature of women's health issues and the extent to which the PHC model is able to cogently address these.

Chapter 2 of this thesis reviews the literature pertaining to PHC. It provides, firstly, a history of the development of the model and a description of its main features. It then reviews the sorts of problems and criticisms of the model that have been cited in the literature to date. It underlines the fact that few studies have been concerned with the interface between the perspectives of local groups and specific aspects of the PHC mandate. In this regard, the viewpoint of women in developing countries is conspicuously missing from the literature.

A theoretical backdrop for the study is provided in chapter 3. Here the researcher explains how the sociology of knowledge and the "gender relations" approach to women and development provide some basic assumptions which inform the analysis that takes place.

In chapter 4, the study context is described. A brief geographical and socio-economic profile of Vanuatu is provided, and following this, the health of the Ni-Vanuatu is overviewed. Available information regarding the health of Ni-Vanuatu women is reviewed in some detail here. This is important for understanding the study findings and appreciating their significance in a broader context.

Chapter 5 describes the research design. Here the researcher presents the four guiding questions mentioned above and explains how they relate to the broader research question. A table (Table 1) is provided in this chapter which outlines the logic of the inquiry. The suitability of the ethnographic method for this type of research is then discussed. Following this, the researcher describes, in some detail, entry into the study setting, sampling issues, the roles of interviews and observations in data collection, and the methods of data analysis used. Issues of generalizability and validity, as well as ethical concerns, are also covered.

Chapter 6 introduces the reader to "Nasilar" village, in which the study took place. The main physical and social features of the village are outlined and, following this, a more detailed description of the daily life of the women is given.

Finally, in chapter 7, the actual study findings are presented. These, being quite broad and comprehensive, are organized so as to address the four guiding questions. Some of the findings, for example, "perceived health priorities",

are expanded to include a number topics which are of relevance for understanding the nature of women's health problems in this context and thereby the suitability or lack thereof of the PHC model. Being an ethnographic study, the findings are primarily qualitative in their nature, relying heavily on actual quotations from the women interviewed. In so far, however, as 69 of the 76 (91%) village women were interviewed, some findings could be tabulated numerically so that the description also includes some very basic descriptive statistics as an indication of the generalizability of the study findings within this village setting.

In chapter 8, the study findings are analyzed. Using each of the guiding questions as a springboard, the PHC framework is interfaced and compared with the health perspective of this group of women. This provides a basis for critiquing the model and reassessing its viability, given the particular health issues that the women have identified. What develops is essentially a feminist critique of PHC, one which asserts that the model is limited by its failure to adequately situate women's health issues in their socio-structural context, more specifically, in the context of gender relations.

CHAPTER 2

AN INTRODUCTION TO PHC AND A REVIEW OF THE LITERATURE

The Development of PHC: Its Historical Context

Since the second world war, with the ending of the colonial era and the emergence of independent nation states throughout the "third world", large-scale economic assistance from advanced industrialized countries to developing ones has been seen as an important part of international diplomacy. Most early assistance programs emphasized industrial and agricultural aid (Justice 1987). With time, however, health problems came to be viewed as obstacles to development and modernization, and funding was soon provided for health and population programs as well. As Justice (1987) points out, however, "he who pays the piper calls the tune", and although multilateral, bilateral, and private organizations work in "cooperation" with governments in developing countries, the provision of funding has always been accompanied by policy guidelines and program directives.

From the 1940s to the early seventies, health policies and programs were oriented to the development of hospital-based services and the control of communicable diseases. Although there were some dramatic success stories in terms of the latter, i.e. the eradication of smallpox, the health of much of the world's population remained appallingly poor and it was clear that it would not and could not significantly improve in this health-care context. Expensive, individualized, western-modeled health care was particularly ill-suited to the needs and resources of developing countries. In terms of human resources for example, the ratio of nurses, doctors, and other health professionals to the population was 10 to 100 times smaller in these countries than in more affluent ones (Benyoussef & Christian 1977). Furthermore, the physical, technological, and human resources that did exist were usually concentrated in urban centers while in developing countries it was not uncommon for 70 or even 80% of populations to live in rural areas.

All of this called for a serious reappraisal of conventional health-care delivery systems and of alternate means, methods, and models for improving health. Thus, the late sixties and early seventies ushered in a new emphasis on the provision of "basic health services" in rural areas and on the importance of community participation in this regard.

The emphasis on community participation was not unique to the health sector. Rather, it was preceded and paralleled by a much broader movement towards popular participation in third world development. The U.N., particularly, was in the forefront of discussions around this theme since it was believed that by involving people directly in the

development process, attempts to promote economic and social development could be accelerated (Midgley 1986). In the early 1970s, it published 2 major documents on the topic of popular participation (in Midgley 1986). Many other groups, including not only WHO, but even organizations such as the World Bank and the Office of Home Economics², produced documents in the early and mid seventies emphasizing the moral and practical virtues of self-help and community participation (in Navarro 1984).

Midgely (1986) explains that the community participation emphasis had several philosophical antecedents³, one of the main ones being western democratic theory, more particularly "neighborhood democracy" and populist ideals. He also notes that certain strands of anarchism provided inspiration and that Kropotkin's "romantic and naturalistic anarcho-communism" closely resembles contemporary community participation ideals. The latter, he points out, is premised on the assumption that cooperation and mutualism are natural human instincts.

Within the WHO, a study conducted in 1973 entitled "Organizational Study on Methods of Promoting the Development of Basic Health Services" was foundational to the development of the PHC model (Newell 1988). This study documented a widespread dissatisfaction of populations with their health care services and documented various reasons for this, such as a wide gap in health status between countries and within countries, the inability of health services to deliver a level of national coverage adequate to meet stated demands, and a feeling of helplessness, on the part of the consumer, that health services progressed along an uncontrollable path satisfying health professionals but leaving consumers wanting (WHO 1973). It concluded that these dissatisfactions were symptomatic of some fundamental errors in the way that the health care needs of populations were being approached and that the role and content of the health services needed to change. It criticized the largely prescriptive role conventionally played by health professionals and underlined the importance of greater community participation and self-determination. It suggested that it was communities themselves, and the individuals within them, who should take the lead in identifying priority health problems, in making decisions with regard to interventions, and in mobilizing available resources to alleviate them. Hence the change from "Health for the People" to "Health by the People" (Newell 1975).

Following discussions around this 1973 report, WHO and UNICEF presented a paper to the 1975 World Health Assembly that attempted to describe the emerging (PHC) model (WHO 1975). The paper was accepted by the assembly and lead to further discussions. Finally in 1978, a week long meeting, sponsored by WHO and UNICEF and attended by delegates from 134 countries, was held in Alma Ata. At this time the official PHC declaration was drawn up. The declaration underlined the "need for urgent action" to promote and

protect the health of all the people of the world (WHO 1978, 2). It stated that a main social target for all governments, international organizations, and the whole world community, should be the attainment, by all peoples of the world, by the year 2000, of a level of health that would permit them to lead socially and economically productive lives. Primary Health Care was, it said, the key to attaining this target.

The PHC Model: Its Central Features

The first and perhaps most central feature of the PHC model is the emphasis it places on the need for communities and individuals to take a more active role in health matters. The Alma Ata document states that "all people have the *right* and *duty* [sic] to participate individually and collectively in the planning and implementation of health care" (WHO 1978, 3) and that PHC is to be undertaken in the "spirit of self-reliance and self-determination" (WHO 1978, 3). This emphasis seems to be based, in part, on ethical considerations regarding the rights of individuals and communities to make their own decisions in health matters, as opposed to having decisions made by outside medical professionals and then imposed on quasi-rational grounds (WHO 1973). It is also based, however, on the very practical realization that in developing countries particularly, where fiscal constraints and manpower shortages have always been major issues, greater community participation and appropriate use of local resources can significantly contribute to improved health.

On a practical level, the PHC literature has suggested various means and mechanisms through which communities can address their health needs and become more self-reliant. These would include the use of simple, low-cost health technologies (for example, improved pit latrines, built from locally available materials, to improve sanitation), the promotion of health education regarding simple means of preventing and treating common diseases, and the training of local people as village health workers. Village health committees have been popular in many contexts as a structure through which communities can organize themselves to begin addressing their health problems. According to Newell (1975) the latter can: set priorities, organize community action for problems which cannot be solved by individuals (i.e. the provision of water supply, basic sanitation), legitimize the village health workers, financially assist the services, and link health activities to wider community goals. The literature also emphasizes that PHC should become integral to community groups already in place such as youth groups, women's organizations, primary school children; these are all important sites for health education and health planning. Within this framework, medical professionals are to take a supportive rather than directive role, providing expertise and referral as needed. According to the WHO literature, the development of self-reliance is central to

PHC philosophy. As Halfdan Mahler, then Director-General of WHO, stated in 1981: "self-reliance...sets people free to develop their own destiny. It is the essence of PHC." (Mahler 1981).

In addition to community participation and self-reliance, the PHC model also emphasizes equality. The Alma Ata declaration charges that the inequality of health status within and between nations is unacceptable and that essential health care ought to be made accessible to everyone. On a practical level, it recommends that health resources be more equitably distributed and that the health service infrastructure be designed so as to make the primary-level health needs of the majority, who often live in the rural periphery, the priority (WHO 1975). What this implies is a funneling of health-care resources away from sophisticated tertiary-level care so that basic curative and preventative services can be made available to everyone⁴.

A third principle on which the PHC model is said to be based has to do with the multifactorial nature of health problems and of the need, therefore, for intersectorial collaboration. The PHC model acknowledges that the etiology of ill health involves not only medical and biological causes of disease but broader factors such as poverty, environmental abuse, lack of education. Hence social and economic development are said to be of basic importance to the "fullest attainment of health for all" (WHO 1978, 2) and PHC, it is said, "requires the support of other sectors" (WHO 1978, 46). The sectors identified as particularly important include the following: "agriculture, animal husbandry, food, industry, education, housing, public works, and communication" (WHO 1978, 4).

Socio-cultural adaptability is also emphasized as an important PHC principle. PHC is said to be a flexible, culturally sensitive approach that will manifest itself differently depending on the particular economic and social characteristics of each context. It is to be based on "practical, scientifically sound, and *socially acceptable* [sic] methods and technology" (WHO 1978, 4). This presumably means that PHC will promote effective (verified as such within the scientific paradigm) health interventions while respecting and preserving, so far as possible, the social and cultural autonomy of the community involved. The emphasis in the PHC literature on the need to involve traditional health care deliverers in PHC can be seen as an extension of this basic tenant.

Finally, the Alma Ata Declaration identifies eight aspects of health care as basic or minimal to PHC⁵. These have come to be known as the "eight essential elements of PHC" and they provide a starting point for community-level PHC endeavors. The first component is education concerning prevailing health problems, particularly the methods of preventing and controlling them. Indeed, this emphasis on education and prevention, along with community participation has subsequently come to characterize PHC as it is popularly

conceived. The other seven components, of which education is stated to be an important and integral part, include the following: promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; MCH (maternal and child health care), including family planning; immunization against infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs (WHO 1978).

PHC in Retrospect: Issues and Obstacles

The past fifteen years have produced an abundance of literature with documentation of various PHC endeavors, some with considerable success (Morely 1983; Bender and Pitkin 1986), many others with demonstrable failure (Justice 1987; Williams and Satoto 1983; Madan 1987). Furthermore, some feel that PHC is in real danger as WHO's paymasters and other funding agents criticize the slow pace of PHC and show signs of favoring the no-nonsense approach of more recent vertical programs (Van Der Geest, Speckmann, and Streefland 1990).

Reasons cited for the limited success of many PHC endeavors are of a varied nature. Some researchers have focused on the practical difficulties involved in translating PHC from theory into practice. Justice (1987) for example, has highlighted the bureaucratic structures through which PHC is disseminated and implemented and the ways in which the latter prevent the development of programs that are either appropriate at the local level or accurately reflective of official PHC philosophy. Similarly, Bosset and Parker (1984) have focused on the administrative context of PHC and the adverse effects of the latter on PHC planning and implementation. And Boerma (1987) has elucidated the difficulties that result from health manpower shortages, the inequitable distribution of health-care personnel, and the lack of training and preparation received by PHC personnel and participants. He has also highlighted the sorts of sectorial issues and interests that can mitigate against intersectorial collaboration. Although the literature pertaining to PHC in Vanuatu is very limited, what has been written has tended to fit within this category; it has focused on issues such as the difficulties involved in managing and coordinating PHC endeavors at the regional and district levels (Harris et al. 1991).

Another portion of the PHC literature has examined the viability of the PHC model itself in the context of socio-political factors which give rise to poor health, particularly in third world contexts. Many critics, particularly those from a political economy perspective, underline asymmetries of power and consequent relations of dominance and dependency on a national and international level. They argue that although PHC pays homage to the

broader context of ill-health and to the need for greater equity in the distribution of health resources, that it still fails to adequately address issues of power and inequality. Sidel and Sidel (1986), for example, assert that a necessary precondition for successful PHC within any developing country is a national commitment to the redistribution of resources and reallocation of power. Werner (1977) argues that even effective preventative strategies associated with the eight elements of PHC (such as immunizations, the construction of latrines, or nutrition education) will, in and of themselves, have very little impact on the lives of the poor so long as these more fundamental constraints to improved health remain unchallenged. Many others (Doyal 1979; Stock 1986; Zaidi 1988) have underlined ill-health as an integral feature of the broader process of underdevelopment and have argued that even the more "innovative" programs (including PHC) of international agencies and governments are relatively insignificant when it comes to addressing the structural barriers to improved health that characterize the economies of dependent capitalist nations.

Of particular interest in terms of the present research, is the literature focusing on the local contexts in which PHC has been implemented and the ways in which the PHC model has failed to articulate with the beliefs, values and priorities of local communities and sub-groups. Although the literature around this theme is quite limited, several researchers have documented the sorts of "malfits" that can exist in this regard.

Community participation, self-reliance, and self-determination, which are basic to PHC philosophy, have recently been brought under scrutiny. Stone (1989), who conducted her research in Nepal, found that the western-based notion of community participation (which, she claims, derives in turn from individualism and an emphasis on "mastering one's own destiny") is not one that automatically fits within villagers' frame of reference and that villagers would more likely welcome a "meaningful sense of interdependence and exchange with outside agencies and institutions" (Stone 1989, 211). She argues that in this Nepalese context, a western type of self-reliance would amount to social and economic suicide. Rifkin (1983), Hamilton (1972), and Madan (1987) have also noted that some third world communities seem to favor a relationship of dependency (on outside agencies) over a move towards greater self-reliance. Van Der Geest, Speckmann, and Streefland (1990) postulate that villagers may have good reason for rejecting the PHC emphasis on self-reliance: "they may rightly gain the impression that highlighting self-reliance is a euphemism for leaving them to fend for themselves" (1990, 1030). The same authors conclude that self-reliance is "a western cultural value that may not be shared at all by those involved in the PHC enterprise at lower levels of social organization" (Van Der Geest, Speckmann, and

Streefland 1990, 1027). In the context of Vanuatu, Harris et al (1991) have noted that some communities have lacked commitment to follow through with the PHC objectives they initially set (usually while attending government-sponsored workshops introducing the PHC concept). This, however, they attribute to community-level political problems or to lack of infrastructural support. They do not consider the possibility that the emphasis on "self-reliance" may not be well-matched with villagers ideas about the means through which desired health changes should come about.

Some researchers have found the PHC emphasis on equity in the planning, implementation, and distribution of health benefits to be at odds with the socio-cultural reality (and belief structures supporting it) of some communities. Madan (1987), for example, in his research in India, has shown how village health committees tend to be composed of village elites and has argued that whenever community welfare measures have been attained, their distribution on an equalitarian basis has been resisted. The moral excellence of equality and equity (or more particularly, the western understanding and application of the terms) may not be a given in all cultural contexts. Failure to recognize this has been the downfall of more than one PHC program (Williams and Satoto 1983).

Research has also indicated that many poor communities would prefer to see the emphasis on cure as opposed to prevention. Stone (1986) found that the Nepalese already had in place an extensive traditional system of preventative beliefs and practices and felt no need for western preventative education; they were more interested in its curative potential. Similarly, Van Der Geest (1982) observed a PHC project in South Cameroon "develop" from a program primarily oriented towards preventative education to an almost entirely curative service differing little from a "pharmacy on wheels", with villagers as well medical staff reasonably pleased with the transition. These researchers argue that in these contexts, PHC has meant the imposition of alien messages and the committant downplaying of immediate concerns. Again, in Vanuatu, it has been noted that, particularly at the community level, many health care workers have tended to focus on curing illness as opposed to prevention. Harris et al (1991) assume that this reflects a professional bias and suggest improved education as the antidote to this. They do not indicate whether or not this curative focus reflects a community preference for curative over preventative.

On a very basic level, there have been hints in the literature to suggest that while the attainment of health may be accorded sacrosanct priority in PHC documents, it may not be similarly enshrined at the village level. While it is probably universally true that individuals value their health, improving health may not be a priority. Health objectives are often side-lined in favor of other more immediate goals and needs such as that for short-term

monetary gain (Van Der Geest, Speckmann and Streefland 1990)⁶. Or, health objectives may be discarded if the social costs of attaining them outweigh their perceived advantages (Foster, 1976). Furthermore, even the WHO definition of health on which Alma Ata mandate is prefaced ("a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"⁷) may find no easy equivalent in the village setting. Recent studies have shown, for example, that even in western contexts, there is little consensus amongst either lay persons or health professionals when it comes to the meaning of "health" (Morse 1987).

If one were to examine the literature pertaining to each of the eight PHC elements themselves, many more dysjunctions between the PHC model and local viewpoints could probably be identified. The fourth element of PHC, maternal-child health, includes family planning, which is perhaps a prime candidate for poor "cultural fit" as the history of family planning in India, for example, so clearly illustrates. The orientation of most international agencies is neo-Malthusian and governments themselves are usually attuned to national economy and political stability (Van Der Geest, Speckmann, and Streefland 1990). On the other hand, as numerous studies (Banjeri 1980) have shown, the interests and views of peasants with regard to family planning are often of a fundamentally different nature. They have plenty of sound reasons for desiring large families from traditional beliefs about the inherent value of children, to the need for old age security, to the help that extra hands can bring to farming.

One cannot be sure that even the need for the "most basic" of the eight PHC elements, such as "safe water supply and sanitation" or "proper nutrition" will be obvious for those within different socio-cultural settings. One study, for example, on drinking water in some Asian countries, reported that the people's concept of what constitutes "good" potable water does not take into account chemical, organic, or bacterial pollutants (Barnabus 1982). Research on the Pitjantjatjara of Australia has indicated that, within this group, little association is traditionally made between health status and nutritional intake (Hamilton 1972). Furthermore, even if western-based education is welcomed in such matters (and as already mentioned, one cannot assume that it is), finding common ground on which to begin providing a plausible rationale or conceptual basis for the latter can be a difficult task. As many researchers have shown, villagers have often already accommodated the efficacy of certain western preventative and curative modalities within their own traditional frame of reference. Madan (1987) for example, describes how the immunizations involved in the eradication of smallpox in India were interpreted in many communities as part of the successful expropriation of the smallpox goddess (apparently the TB goddess is a current manifestation of the same belief

system). Similarly, Leprowsky (1990) describes how the efficacy of penicillin within a village in Papua New Guinea was attributed to the ancestral spirit inhabiting the health care worker who provided it.

What all of this highlights is the ways in which PHC, rooted within a particular knowledge paradigm, may be difficult to reconcile with local perceptions regarding the nature and meaning of health problems and the means through which health improves. Although within medical anthropology there has been a long tradition in the study of lay opinions regarding health and illness across various cultures, there has been surprisingly little research focusing on the ways in which the perceived needs and preferences of local groups, and their understandings of the nature of health problems, relate to the official PHC agenda, an agenda which, for many reasons, third world governments have felt obliged to take up. Van Der Geest, Speckmann, and Streefland (1990) comment on this paucity in the literature, suggesting that it may reflect the fact that policy makers do not favor research of this nature possibly because they anticipate the sorts of findings that might result and are uncertain as to how they would put them into practice.

If little research has focused on the interface between the PHC model and the beliefs and values of particular communities in the developing world, even less has been written with regard to the *perspective* of specifically *women* in these contexts and on how the latter relates to the PHC mandate. On the whole, the viewpoint of women is sadly lacking in the PHC literature. This is not to say that the *topic* of women is missing; indeed women figure quite prominently in discussions around operational aspects of PHC programs in the context of their reproductive needs, their crucial role as primary caretakers and health educators within the family, and in their role as consumers of health services (MacCormack, 1989). There have also been some ethnographic studies in the more general health literature which have examined particular aspects of indigenous women's health beliefs which would fit under the broad umbrella of PHC; studies pertaining, for example, to infant nutrition (Launer and Habicht 1989) or to family planning (MacCormack 1985). While, in most cases, these researchers draw out the implications of their findings for improving health education and planning, few relate their findings specifically to the PHC framework. And virtually none have attempted to critically assess the underlying premises of the PHC model vis-a-vis the health perspective of women.

Footnotes

¹There is unfortunately no satisfactory term to denote those countries or contexts that are economically poor in relation to their northern (or western) neighbours. "Third world", "underdeveloped countries", "developing countries", "southern", "less developed" are some examples and all are, it seems to me, theoretically and/or politically problematic since they tend to be reductionistic (blanketly grouping all these countries as one), since they assume the western world as the standard or reference point, and because they often subtly (or not so subtly) imply the superiority of the west. Although I do use these terms for lack of an alternative, I do so reluctantly and cautiously, with these qualifications in mind.

²This is, according to Navarro (1984), the intellectual center of the British pharmaceutical industry.

³In addition to those mentioned here, are the "community development" movement in third world countries (originally initiated by colonial officials and missionaries) and trends in western social work and community radicalism. These are not of relevance to the discussion here and so are not expanded upon. See Midgely (1986).

⁴When it comes to reducing health status disparities between advanced industrialized countries and developing ones, the document emphasizes the need for all countries to cooperate in a spirit of "partnership" and "service" since the attainment of the health of people in one country "concerns and benefits every other country" (WHO 1978;5). Apart from emphasizing the important role of disarmament in freeing up more of the world's resources for health, the document forgoes any more critical analysis of the etiology of third world poverty, including the sorts of changes that might be required of north in order for the health of its southern neighbors to improve. At the community level as well, the document seems to emphasize notions of shared interests and cooperation downplaying conflicts of interest and power relations.

⁵At this point, PHC philosophy is translated into methodology. This seems somewhat ironical given that PHC was said to represent an antidote to the more prescriptive approaches of the past.

⁶Some would argue that this is in fact a "health" goal. The issue is discussed more completely in the last chapter of this thesis.

I am aware that in 1984, the definition was changed to read:

Health is the extent to which an individual or group is able to, on the one hand, realize aspiration and satisfy needs, and on the other, to change or cope with the environment. Health is therefore seen as a resource for daily life, instead of as an objective of living.

In either case, the same point holds.

CHAPTER 3

A THEORETICAL FRAMEWORK FOR THE STUDY

This study has been informed, mainly, by two theoretical currents, both of which involve marriages between certain sociological premises and the health domain. These include, firstly, the sociology of knowledge in application to the health literature, particularly with reference to officially sanctioned health discourses. An awareness of theoretical concepts from this sociological tradition is important for the analysis of PHC philosophy that takes place in the final chapter. Secondly, in so far as this study focuses on the health of women in a developing country, the feminist health literature, and more particularly the "gender relations" perspective, also provides a theoretical backdrop for the analysis that takes place.

The Sociology of Knowledge: Health Discourse as Ideological

The sociology of knowledge, broadly speaking, maintains that any knowledge system can be fruitfully analyzed with reference to the social context out of which it has arisen. Moreover, it considers dominant discourses, paradigms, and conceptual models ideological to the extent that they reflect and reproduce the complex of social relations (particularly the power relations between different groups) in the context of which they have evolved. This is not to say that a popular health philosophy like PHC cannot be challenging or even emancipatory in certain respects, but simply that, even so, it will bear the imprint of the social structure in which it gestated. In this study, PHC is not accepted uncritically, as if somehow grounded in an "objective" perception and interpretation of reality; rather it is recognized as being based on certain *assumptions* about the nature of ill-health etiology and the nature of social life. And being a widely accepted and disseminated health philosophy, it is seen as important to at least ask about the ways in which these assumptions may reflect the world-view of dominant social groups¹ and about how the model may act to reinforce the current social order.

The effect of social determinants on human thought is a subject which has a long history dating back to the work of Durkheim, and more particularly, within the German tradition, to the work of Marx, and later Mannheim. Although more recent scholarship has rejected the more reductionist Marxist approaches which posit a very mechanistic relationship between the economic base of society and its cultural forms, the basic premise that what passes for "knowledge" in any society is deeply rooted in particular configurations of social relations continues to provide fertile ground for investigation. The concept of hegemony,

which derives primarily from the work of the Italian Marxist, Gramsci, has been very useful in refining the more mechanistic concept of ideology that appears in some Marxist literature. Hegemony is a deeply inclusive concept referring to the idea that individuals within a society possess a consciousness so saturated with structures and forms rooted in underlying social relations that they are unable to see any serious alternatives to the economic and cultural assemblage of their world (Apple 1982). This concept has particular relevance to the health domain wherein empiricism and atheoretical pragmatism have dominated to such an extent that alternative models for the analysis of health issues have had little room to develop.

The tools for analyzing hegemony within various discourses have been borrowed to a large extent from literary theory. The techniques of "deconstruction", which initially were applied only to literature and philosophy but then extended to nonliterary texts, involve clarifying what is marginal, deemphasized, or absent from a text (Waitkin and Britt 1989). Marxist theorists have emphasized that an essential task of critical theory should be to search for elements of *social context* (elements such as class, gender, age, and race) that have been marginalized or excluded. In this sense, ideology is seldom explicit or manipulative, and as Waitkin and Britt (1989) emphasize, this has been particularly the case in the health literature. Ideology manifests itself by a "lack of explicit discussion of alternatives to the present, or by a deemphasis of contextual problems or an absence of critical attention to such problems" (Waitkin and Britt 1989, 587). In this way its transmission is a subtle process rarely reaching the consciousness of participants. Indeed this is where its power lies; in subtly expressing only a narrow range of possibilities for action, while repressing others.

Relative to health, the subject of ideology has a much more definite history in the education literature where recently people like Apple, Giroux, and Aronowitz have examined "knowledge" claims and schools of discourse within the educational enterprise in relation to dominant patterns of social organization (Apple 1990, Giroux 1983, Aronowitz and Giroux 1993, Beyer and Apple 1988). In the health literature, there is no similarly well-circumscribed body of literature, rather a much sparser disaggregated group of articles. Most of what exists is, loosely speaking, written from a "political economy" perspective, wherein class analysis, or often the metropole-periphery model, provides a basis for critiquing current health policy innovations. Although the term "ideological" may not be used, what is stated, or otherwise implied, is that dominant health discourses are unable to cogently address the health problems of marginalized people (often the poor) because they fail to situate them in the larger context of their structural determinants (and ultimately, most contend, in the context of capitalism and imperialism). By

inadvertently directing our attention away from the root problem, these approaches then become *part of the problem*. The work of Doyal, The Political Economy of Health (1979), is an example of this kind of research. Others such as Morgan (1990), Whiteford (1990), Zaidi (1988), and Stock (1986) have similarly critiqued dominant health discourses, particularly those addressing the health of the poor.

Within the sociological literature there has been some research at the micro-level, examining, for example, medical discourse between doctors and patients. Waitzkin and Britt (1989) have analyzed transcripts from a variety of interactions between patients and their doctors in an attempt to develop a critical theory of medical discourse. In this case, what is examined is how the content of these exchanges, more specifically what the conversations between patients and their physicians typically marginalize or exclude, reinforce current patterns of social organization. Another example of this sort of research is that of Webb (1984) who, grounding her work in a more phenomenological framework, examines the experiences of women undergoing hysterectomies. She analyzes various aspects of their exchanges with medical doctors, relating these to the broader context of power relations in which they take place.

With regard to PHC Philosophy, both Navarro (1984) and Zaidi (1988) have critiqued the Alma Ata declaration itself. Navarro closely examines what the PHC document addresses, what it marginalizes, and what it omits, and argues that it is essentially conservative with regard to the sorts of socio-political changes which would be required to change the health of the marginalized, i.e. a political and economic restructuring of the relationship between the capitalist metropolises and the impoverished periphery. While the Alma Ata document assumes a primarily technical administrative discourse (thereby appearing quite apolitical), he highlights several subtle features of the declaration which reveal its normative underpinnings and ultimately what he sees as its conservative nature. He underlines, of particular relevance for this study, that the article is based on a model of collaboration wherein power relations, at the international, national, and community level, are inadequately dealt with. What the document ultimately calls for, he charges, is "organizational and technological change within the framework of current power relations" (Navarro 1984, 471). Although he emphasizes *class* in its relationship to development and health status, and the failure of the Alma Ata document in this regard, he does note that the document is equally conservative when it comes to situating health and development issues in the context of gender. Zaidi's argument is similar to Navarro's: he also charges that the PHC document fails to cogently address the root cause of ill-health, which he identifies as poverty, and underlying this, existing class relations. And although he does similarly mention the failure of the document to adequately situate the health of women in its socio-

structural context, he does not develop his thinking on the matter.

The Situating of Women's Health Problems:
Gender Relations as a Context

If the concept of ideology, then, provides the basis for approaching the PHC model with a critical eye, the literature on women's health and gender provides a framework for understanding and interpreting, that is for socially *situating*, the health issues that come to the forefront in the course of this study.

To date, the dominant paradigm through which women's health in developing countries has been approached has cast women as mothers or future mothers emphasizing their reproductive and child-care roles. Although this was certainly the case in the earliest health and development initiatives, even in the 1980s, the World Bank, for example, adopted a "safe-motherhood" strategy, while UNICEF and others focused on child-survival and maternal mortality (Rathgeber and Vlassoff 1993). While this emphasis reflects some fundamental human needs and rights, it also has the effect of casting women, once again, as child-bearers, rearers, and homemakers, with little attention to women in their productive roles, much less to the whole issues of male responsibility in reproduction (Goetz 1991). Furthermore it directs attention to certain well-circumscribed needs and conditions relating to women and reproduction, thus marginalizing considerations of women's *overall* health and well-being and the larger socio-structural context in which their health problems become meaningful (Rathgeber & Vlassoff 1993).

Articles seriously examining the linkages between women's health and its social context (more particularly relationships of differential power rooted in social determinants such as class, age, or gender) comprise a small, rather disaggregated literature. Doyal (1989) has examined women's health issues in the British context, arguing that women's oppression and concomitant health problems become intelligible in the context of *both* gender and class divisions. In this context, she attempts to develop a "Socialist Feminist Epidemiology" in which many of women's health issues, such as the hazards of domestic labor, industrial risk, violence, and certain types of cancer, are rendered explicable in the context of the patriarchal and capitalist nature of society. Although few others have attempted such comprehensive accounts of the etiology of women's health problems, the relationship between social context, more particularly patriarchy, and various aspects of women's health has received attention. Borasso (1990), for example, in analyzing the factors surrounding maternal mortality in Brazil, argues that while on one level it is factors such as malnutrition or lack of access to health services that account for maternal

mortality, the real underlying causes relate to the social and economic position of women and their lack of autonomy in health matters; in short, the fact of their subordination. She concludes that it is, to a large extent, the social environment which causes illness for women and that the struggle for women's health will necessarily include a struggle for the transformation of social relations. Indeed, it is this framing of health issues, within in the context of the need for social transformation, which she says distinguishes feminists from institutions such as the World Bank or even the WHO. In some of the more recent AIDS literature as well, one finds this theme as several authors have identified the low status and relative powerlessness of woman in certain contexts as a key factor contributing to their vulnerability to HIV infection. Ankrah (1991), for example, concludes that in the African context it is a new socialization and orientation to male/female relationships that is called for.

Recently, a "gender relations" approach² to women's health in developing countries has begun to appear in the literature. This has, no doubt, emerged from the broader trend in the WID (Women in Development) literature to shift over to a GAD (Gender and Development) framework. In the seventies and eighties, there was an emphasis on the importance of integrating women into development initiatives but inadequate consideration was given to the everyday context of social relations which often impeded them from fully participating or benefiting. The gender relations approach is one which focuses on the social context of women's lives, more particularly one that underlines gender relations as an *organizing principle* in society. It focuses on the relationship between women and men, on the roles, expectations, and behaviors that are socially attributed to each, and on how the nature of these, in the context of other social variables (i.e. class, age, nationality), effects women (and men) in various aspects of their lives. It acknowledges that the everyday norms and meanings that constrain and/or empower women are rooted and sustained by their roles in production and reproduction and reinforced by the cultural apparatus of society. Therefore, while it strongly rejects biological determinism, it recognizes that the relationship between men and women is integral and essential to society as we know it and cannot be easily disentangled or abstracted from it. Ostergaard outlines the main features of the gender approach as follows:

Gender refers to the qualitative and interdependant character of women's and men's position in society. Gender relations are constituted in terms of the relations of power and dominance that structure the life chances of women and men. The gender divisions are not fixed biology, but constitute an aspect of the wider social division of labour and this, in turn is rooted in the conditions of production and reproduction

and reinforced by the cultural, religious and ideological systems prevailing in society. (Ostergaard 1992, 6)

Applied to health, a gender approach would examine the nature of this relationship between women and men and how it affects and interacts with other aspects of women's (and men's) lives to determine their chances for good health. Rathgeber and Vlassoff (1993) have recently commented on the need for a gender-sensitive approach to women's health in developing countries. They emphasize that the latter acts as a corrective to previous approaches in so far as it extends considerations of women and disease beyond the biological concept of sex to the sociological concept of gender, emphasizes the well-being of the whole person rather than viewing women only functionally in their roles as mothers, and situates health problems in the much larger context of every day life and social structure.

For this study, the main merit of the gender relations approach is that it provides a basis for the assertion that one's chances for good health are rooted in power relations and that the nature of the relationship between women and men is of fundamental importance in this regard. It is acknowledged that the subordinate position of any group of women (or any individual woman for that matter) necessarily results from a complexity of oppressions rooted in class, ethnicity, race, age, creed and gender and that the health of the women in this study could be understood and analyzed by taking other aspects of their social location as a starting point³. Indeed, contemporary third-world feminists assert that to perceive the oppression of women as a simple dichotomy of victims and oppressors (i.e. women and men), rather than a result of multiple oppressions which interact differently with different women as a result of their particular social and cultural location, is deficient (Goetz 1991). Many, for example, emphasize the interrelationships between patriarchy and neo-colonialism and the idea that one cannot be adequately addressed without reference to the other (Moser 1991). Some third world feminists, drawing on post-modernist feminism, even argue that the binary thinking which is at the root of the logic which creates of schism between men and women is a western feminist construction that may have less relevance and explanatory usefulness in other cultural contexts (Mohanty 1988). In so far, however, as the discourse of the women in this study seemed to highlight gender relations as particularly significant in understanding the factors that affected their health, gender is taken as the primary context for analysis. The contention of some feminists that focusing on gender relations to the exclusion of other social factors means regressing from a full-color analysis to black and white is accepted as valid. While it does not make the analysis of women's health in this context less significant, it does set limits on the latter as only part of a much larger, more complex picture, and not at all the "last word".

Footnotes

¹"Dominant social groups" refers, in this case, to those groups that are dominant in the global context (caucasians, males, the young, etc.), the national context (the elite vs the poor) and also to the dominance of the metropole centers (western, "developed" countries) over the periphery (those in "developing" countries). The latter assumption particularly, that PHC philosophy may embody and reflect the dominance of the metropole over the periphery is bound to be met with some disagreement, since representatives from all over the developing world sit on the WHO Assembly and were involved in the development of PHC. It is contended, however, that it is unlikely that these representatives are typical of those they are to represent; all will have been educated, socialized, and acculturated, during their secondary and tertiary education, through texts, journals, and colleagues into what might be called the dominant world-view and health perspective of the metropole. Numerous researchers, for example Altbach (1971; 1975; 1978), have underlined the idea that in most developing countries formal education, despite many attempts to the contrary, acts to homogenize students so that they develop a shared consciousness, a common body of thought categories and thought patterns. As Bourdieu (1976) points out of western-modeled schooling, there develops a "consensus in discensus" referring to the fact that those who would otherwise have nothing in common are still in agreement concerning the accepted questions on which they are opposed.

²I am using the term loosely. Some of the terms found in the literature would include "gender analysis" approach, or a "gender-sensitive" approach.

³In particular, "class" (i.e. their class position in the context of the global economy) could be taken as another starting point for the analysis. The discourse of the women in this study highlighted certain economic features of their lives (see Chapter 7, "Perceived Etiology of Health Problems") as important in accounting for their health status.

CHAPTER 4

THE STUDY CONTEXT

An Introduction to Vanuatu

The Republic of Vanuatu, formerly known as "New Hebrides", is located in the south-west pacific, within the area classified as Melanesia. Its neighbors include Solomon islands to the north-west, Fiji to the east, and New Caledonia to the south-west. An archipelago composed of eighty-some small islands, it runs north and south spanning a distance of almost 1100 kilometers. The two largest islands are Santo and Malekula, but there are 10 others of over 100 square miles, and some sixty smaller islands. Most islands have rugged mountainous interiors, with narrow coastal strips where most of the inhabitants live.

According to the 1989 census, the population of Vanuatu is 142,944 (Government of Vanuatu 1991). As in most developing countries, the population is young, with 44% of the nation's people being under 15 years of age (Government of Vanuatu 1991). Approximately 93% of Vanuatu's inhabitants are Melanesian, their ancestors migrating from Southeast Asia several thousand years ago (Republic of Vanuatu 1984). They settled in small villages throughout the islands and lived by means of hunting and gathering and subsistence agriculture. Today Vanuatu is characterized by enormous cultural and linguistic diversity which, together with the geographical features of the country, has made unification a difficult undertaking. Previously a joint condominium of the French and English, independence was secured in 1981. The government, which is a parliamentary democracy, was lead by the Vanuaku party up until the most recent 1991 election when it was replaced by a coalition government. The country's constitution identifies an important role for the National Council of Chiefs which advises on matters pertaining to culture and custom, as well as the Island Councils which also have an advisory role.

The economy of Vanuatu is based on trade, tourism, and agriculture, copra being the most important agricultural product. Although the early 1980s were characterized by a considerable growth in the GNP and an optimism that perhaps the newly-formed government's goal of self-reliance was attainable, the years that followed brought a down-turning of the economy. This resulted primarily from falling copra prices, a reduction in tourism, and a number of cyclones which caused considerable agricultural and infrastructural damage. For a variety of reasons, not the least of which is its strategic location, Vanuatu receives one of the highest amounts of aid per capita in the world (Roberts 1987). Providers include firstly Australia and Japan, but the European Economic Community, particularly the United Kingdom and France, also maintain a high profile.

At present, approximately 86% of the population live in

rural areas (Government of Vanuatu 1989) where traditional village life is the norm. Here the villagers practice subsistence gardening in much the same way as their ancestors did, although cash crops have come to play an increasingly important role in the modern era. Despite the growing influence of the western world, traditional beliefs and values remain strong in many areas. At the same time, and with little apparent conflict, the society is strongly Christian, the church having considerable moral authority at the national¹ and local level.

Health in Vanuatu

Available epidemiological data² would indicate that the health status of the Ni-Vanuatu compares quite favorably with that of people in many other developing countries. Yet compared with many of its south pacific neighbors, and with western countries, it is still quite poor. Infant mortality rates, for example, which are often used as an indice of a nation's health, are estimated to be between 55 and 60 per thousand (UNICEF 1991). The corresponding figure for most African nations would be well over 100, while for western countries, less than twenty.

Respiratory infections, skin diseases, malaria, and intestinal infections are the most common causes of sickness reported by the health service for the population as a whole (Republic of Vanuatu 1991). Malaria is a constant problem, rainfall and topography being important factors in this regard. Other important causes of morbidity include tuberculosis, meningitis, anaemia, and, particularly in the case of children, malnutrition. According to the national nutrition survey (Hung 1983), about 1 in 4 children are underweight for their age, and within the 12-17 month age group, 48%. In general, there are seldom food shortages in Vanuatu (apart from following cyclones) and in most areas some variety of foods is available. Recent health initiatives have therefore focused on educating mothers about how to prepare more nutritional meals for their families from locally available foods.

Inadequate water supply and sanitation pose serious health risks in terms of communicable diseases, particularly diarrheal disease and skin infections. An Environmental Health survey in 1988 (Republic of Vanuatu 1988) found that about 62% of communities had access to what was considered a safe and reliable water supply. This represents a considerable improvement over the situation in the early 1980s when the figure was 30% (UNICEF 1991). Rural water supply projects, funded almost entirely by overseas aid, have played an important role in these improvements, one report stating that nearly 40% of households had benefited from such water supply schemes (UNICEF 1991). With regard to sanitation, the 1988 survey found that only 12.6% of households had what were considered adequate latrines³,

although it was said that 60% used pit latrines that could be upgraded to an adequate level. At present, a national environmental health initiative is underway (also funded largely by overseas aid) to introduce and help construct VIPs (ventilated improved pit-latrines) and water seal toilets in villages throughout the country.

The country's infrastructure has functioned relatively efficiently up until recently⁴. This means that basic health services are available in most areas and secondary- and tertiary-level care in the major centers. However, the geographical features of the country, with concomitant problems of transport, mean that secondary and tertiary level care, particularly, are not readily accessible for many people.

The Health of Women in Vanuatu: An Overview of Available Information

Unlike global patterns, men have tended to outlive women in Vanuatu. Estimates based on the 1979 census showed that while the average Ni-Vanuatu man could expect to live to 56 years, the average life expectancy for a woman was only 54 years (Bedford 1989). Likewise, the female death rate was estimated at 13 per 1000 while the male death rate was 11 per 1000 (Bedford 1989). Although according to more recent demographic data, the gap may be narrowing (i.e. life expectancies estimated at 62.4 for men and 61.0 for women in 1988 [Republic of Vanuatu 1988]), the underlying pattern is significant. Some have speculated that the differences in mortality rates and life expectancies may be related to the heavy work burden Ni-Vanuatu women carry, in both the reproductive and productive spheres.

The total fertility rate (the average number of children born to women during their child-bearing years) in Vanuatu is 5.1. However, in many rural contexts, families with more than six children are not at all uncommon (Foy, 1991). Furthermore, it has been estimated that in Vanuatu the majority of women will spend over one-third of their reproductive lives either pregnant or breastfeeding (UNICEF 1991). It is not difficult, therefore, to understand that the health status of women in Vanuatu is closely tied to their reproductive role. In 1986, for example, diseases of the reproductive system and complications of birth and pregnancy accounted for nearly 30% of hospital admissions for adult women, excluding normal deliveries (UNICEF 1991). As a result of this close connection between the health of women and their reproductive role, most studies undertaken to date have focused on the maternal role of women, collecting information related to pregnancy, delivery, and post-partum, as well as family planning. Although epidemiological reports often breakdown leading causes of morbidity and mortality by age, they seldom do so by sex. The effect of all of this is that although there is considerable data available about the health status of women

within their reproductive capacity, little information is available with regard to their health status outside of this role.

Maternal mortality figures are actually quite low; there is less than 1 death per 1000 births nationally (UNICEF 1991). This figure is based, however, on reported hospital births, and approximately 30% of births go unreported (Singleton 1988). The actual figure is probably much higher, as it is these women who deliver in the village without medical backup who are at greater risk. The figures do indicate however, that people who deliver in hospitals or dispensaries are at low risk of death, and that the important issue is service coverage.

The National Nutrition Survey (Hung 1983) found that women tend to have diets high in energy foods (i.e. yam, taro, banana) but low in protein and "protective" foods (i.e. vegetables and fruits relatively high in vitamins and minerals). Anaemia is also a significant problem in pregnant and breastfeeding women, the same study finding 55% of these women to be anaemic (having hemoglobins of less than 12g/100mls). A more recent study found one in five antenatal attenders to be anaemic (Singleton 1988). Data with regard to anaemia in the remaining population of women is limited. One study, which surveyed some urban as well as some rural areas, found that the proportion of non-pregnant women who were anaemic varied between 9% and 14% (Department of Health, WHO, & SPC 1985). In some areas of the country, anaemia is thought to be accounted for by the relatively high prevalence of thalassemia but in others it is thought to be primarily a result of dietary insufficiency, malaria (which is more easily contracted during pregnancy due to a lowering of host immunity), and parasitic infections (Hung 1983). This nutritional data is particularly significant when one considers the heavy manual work that many women undertake. According to one survey (Department of Health, WHO, & SPC 1985), in some areas roughly 85% of women are involved daily in what is classified as moderate to heavy work.

A 1985 study indicated that unlike in many other Pacific countries, non-communicable diseases (i.e. hypertension, diabetes) are not yet prevalent in Vanuatu, although they are slowly increasing, particularly in urban areas (Department of Health, WHO, & SPC 1985). Cancer generally has a low reported incidence (UNICEF 1991). Of female cancers, cervical cancer is by far the most commonly reported, and between 1980 and 1986 accounted for 25% of all malignancies in women (UNICEF 1991).

To date, sexually transmitted diseases are primarily a problem of urban areas, where the major reported S.T.D. in 1987 was Gonorrhoea (UNICEF 1991). There have, as yet, been no reported cases of HIV infection in Vanuatu, although a health education program with regard to AIDS has already been in place for some time, since almost all neighboring Pacific countries have some reported cases.

Footnotes

¹For example, the National Council of Churches is a widely respected and very influential organization in Vanuatu.

²One must bear in mind that the reporting systems are not that reliable and many deaths and sicknesses go unreported. Most of these figures are estimates based on reported cases.

³Adequate latrines were considered to be either water-seal toilets or ventilated pit-latrines .

⁴At present (January 1994) the civil servants have been on strike for two months and this has interrupted services.

CHAPTER 5

METHODOLOGY

I) General Framework for Research

In this study, the ethnographic research method was used to elicit and analyze the health-related beliefs, preferences, and practices of a group of village women in Vanuatu. Although the domain of inquiry was very broad, the following questions were used to guide data collection and focus the research: 1) To what extent is improving health a goal or a priority for these women? 2) What sorts of health problems do these women experience in their everyday lives and what do they consider to be their priority health needs? 3) What health interventions do these women currently use and what etiological beliefs undergird them? and 4) How (through what or whom) are desired health changes to come about?

The broad nature of these guiding questions was intended to facilitate a research process that would proceed in an inductive qualitative manner rather than deductively from a predetermined framework. At the same time, the questions were designed to facilitate the collection of data that would result in a descriptive account that would be highly relevant when examined vis-a-vis the premises and presuppositions underlying the official PHC model. Ultimately the data collected would be used to address the following research concern: What is the relationship (i.e. "fit") between the health perspective of these women and the PHC framework? In what ways do the two correspond and where do they diverge? If there are dysjunctions between the two, how are they to be accounted for?

Table 1, on the following page, shows the relationship between each guiding question and the PHC model. It should be apparent that each guiding question calls into question some basic premises of the model. As with most ethnographies, the descriptive account resulting from this study (presented in chapter 7) comprises a broad and comprehensive picture, rather than a "neat" deductive-type answer to each of the guiding questions. The third column of Table A therefore is included so that the reader can see, at a glance, which sections of the ethnography apply to which guiding question¹.

II) The Research Method: Ethnography

Ethnography, which has a long history in anthropology, can be defined as "the descriptive analysis of a culture" (Robertson and Boyle 1984, 44). It is a research method that is used to develop an understanding of life from the "emic" point of view, that is from the perspective of the participants in the setting under study (Morse and Field

TABLE 1
AN OUTLINE OF THE LOGIC OF THE INQUIRY

SOME BASIC PREMISES OF THE PHC MODEL	GUIDING QUESTION FOR THE ETHNOGRAPHIC INQUIRY	SECTION OF THE ETHNOGRAPHY ADDRESSING THE GUIDING QUESTION:
* The attainment of health is a most important social goal. * There is a need for urgent action to promote & protect the health of all people of the world	1) To what extent is improving health a goal or priority for these women?	A) Health as a Priority for Women
* Health activities in any community should minimally include 8 elements : 1. Health education concerning prevention and control of prevailing health problems 2. Promotion of food supply & proper nutrition 3. Safe water supply & basic sanitation 4. Maternal/child health care (including family planning) 5. Immunizations against infectious diseases 6. Prevention and control of locally endemic diseases 7. Treatment of common diseases & injuries 8. Provision of essential drugs	2) What sort of health problems do these women experience in their every day lives and what do they consider to be their priority health needs.	B) Perceived Health Status and every day Health Problems D) Perceived Health Priorities
* Appropriate methods and technologies for improving health are those which are "practical, scientifically sound and socially acceptable". * Recommended interventions are oriented to bio-medical and socio-economic factors in ill health causation.	3) What health interventions do these women currently use and what etiological beliefs undergird them?	C) Common Health Practises and Interventions E) Perceived Etiology of Health Problems
* Community participation, self-determination, and self-reliance are keys to improving health.	4) How (through what or whom) are desired health changes to come about?	F) Change

1985). In health-related research, ethnography has recently been increasing in popularity, to a large extent because it can be used to direct attention to the beliefs and values of health consumers, as opposed to those of health providers (Leninger 1987). Health providers frequently incur difficulty and frustration precisely because they project onto other cultural groups the dominant health paradigm which they themselves use to interpret and understand health phenomena, incorrectly assuming it to be a universally shared perspective.

The ethnographer obtains ethnographic data primarily through participant observation and interviews. As the social structure, language, and world-view of a given cultural group are probed and examined, the researcher attempts to elucidate the beliefs, values, and understandings that characterize the group and ultimately to develop a subjective understanding of life from within the group's frame of reference. Whereas, in quantitative research, the objective is usually to determine the distribution of some predefined attributes within a population or to test the relationship between variables, in ethnography the researcher works inductively in order to produce a holistic account of the life (or a particular aspect of it) of a particular social group, an account that is characterized by richness, depth, and insightfulness (Morse 1986).

The choice of an ethnographic research method was based on several considerations. Given that this study involves a comparison (of the PHC model with the health perspective of a group of Ni-Vanuatu women), it could have been undertaken using a more quantitative methodology such as a survey. It was felt, however, that doing so would mean taking PHC concepts, a priori, and measuring them up in a setting where they did not originate and may well have little meaning. This would not only represent a form of cultural and epistemological imperialism but severely constrict the scope and nature of the data that could be collected. As Sturtevant (1964) has emphasized, irrelevant questions inevitably result in the collection of erroneous data. A fairer approach, it seemed, was to initially "bracket off" PHC (conceptually speaking) and to work inductively, attempting to develop an "emic" description that could later be compared with the model. It was the ethnographic method that best facilitated this research objective.

III) Study Setting: Access and Entry

This study took place in a coastal village on Malekula island, Vanuatu. The researcher obtained permission to conduct the study from the Vanuatu Department of Health in March of 1991. Once on Malekula, selecting the particular village in which to conduct the study involved consulting with the Malekula area district health supervisor, the

women's affairs officer, and the MCH (Maternal-Child Health) nurses who regularly visited all the villages in the area to conduct clinics. The researcher spent one month accompanying the MCH team as they conducted clinics in north-east and central Malekula. This provided an opportunity to become familiar with the area, informally meet women in some of the villages, and obtain information as to which villages might be suitable for the study. After narrowing the choice to two or three, "Nasilar", as it is referred to in this study, was chosen. It was chosen on the basis of its relatively large size (which meant there would be a large number of women from which to select key informants), its close proximity to Norsup where the researcher would be stationed (i.e. within an hour's drive), and, most importantly, because it was felt by all consulted that the women, as well as the chief and pastor of this village, were relatively open and likely to permit the researcher to conduct interviews and make observations.

After sending letters of introduction to the pastor and the church women's group (this was suggested by the women's affairs officer as the appropriate channel of entry), an introductory meeting was arranged which all village women were invited to attend. There was a good representation of women at this meeting (forty to fifty), including the leaders of the two women's groups in the village. At this time, the researcher introduced herself and explained the purpose of the study, the methods of data collection that would be involved, and the expected uses of the study findings. The women's affairs officer for the area was also present and translated some of what was said into the vernacular for the women. After some discussion, the women said that they would like to participate. The next week the researcher attended the women's weekly church meeting. Using this as an initial basis for meeting women, it was possible to arrange to spend time with some of them gardening and in this way to begin making observations and conducting interviews.

IV) Data Collection

In this study, data was collected through unstructured and semi-structured interviews² and participant observation. Data collection involved two phases. During the first four months of the study, 10 key informants were interviewed using a relatively unstructured approach. During the second phase of the study (the following four months), a semi-structured interview guide was formulated and used to interview 69 out of the 76 village women. Participant observation took place throughout both phases of the study.

Interviews

Sampling Techniques

During the first phase of data collection, ten key informants were chosen according to the "purposive sampling technique" (Morse 1986). This meant that the researcher attempted to discover and engage those informants who were most willing to disclose information regarding the life of women in the village and those who seemed to be most insightful and articulate in this regard. The small sample size and the use of a non-probability sample were considered most appropriate given that the main objective of the study was not to attain findings that would be generalizable (the reason for the large random sample utilized in most quantitative studies), but rather to acquire a body of *rich* and *meaningful* data. Random sampling might actually have interfered with the selection of those informants most able to provide this. Furthermore, the intense and comprehensive nature of this sort of data collection, more particularly the time and energy that it required of a single researcher, meant, at least during this first phase of the study, that only a relatively small number of informants could be interviewed.

Key informants were therefore chosen according to the following criteria: they had to be women who were residents of Nasilar village, they had to be fluent in Bislama (since this is the language in which the interviews were conducted), and, as noted, they had to be relatively open, knowledgeable, expressive, and willing to disclose information about their lifeways and their health. On a practical level, this meant choosing from the women I knew (or was getting to know), those who seemed most interested and articulate and arranging to spend time with them. Sometimes this meant going with them to work in the garden, helping cook, catching crabs, or building chicken fence. On other occasions it simply meant relaxing together by the sea or sitting in the house talking.

Although interviews with key informants proved quite fruitful in terms of allowing the researcher to develop an understanding of the socio-cultural context of these women's lives and to begin delineating paramount themes of relevance to health, it was still apparent, after four months of study, that the descriptive account was not complete and that the data were not saturated³. There were several reasons for this. Firstly, although some key informants provided very useful accounts of health matters, in some instances those who had initially appeared most open or most interested were not. Some, for example, seemed to be primarily concerned about accommodating and pleasing the researcher, while others seemed concerned to promote a positive image of their village. It took time to recognize these things. Also, in some cases the bislama of the interviewee, the interviewing skills of the researcher, or a

combination thereof meant that the interviews could not progress beyond a fairly superficial and unidimensional level.

For the above reasons, it was decided that the sample needed to be broadened. Although "snowball" sampling⁴ might have been appropriate at this point, it was felt, after considerable deliberation, that it would be best to try and interview all of the village women. This was partly because key informants had tended to be those individuals who were most confident, socially active, and expressive and more marginalized village women who might be able to add significantly to the account were not being interviewed. It was felt that contact with these women would only be possible and perceived as acceptable if the researcher arranged to interview everyone. A second reason to broaden the sample so as to include everyone had to do with diplomacy: in so far as many women liked to spend time with a westerner, whether for the sake of curiosity, to show hospitality, or for reasons of prestige, it became clear that it would be politically expedient to be associated with not just a few women but with, so far as possible, the village women as a whole. Indeed, the researcher became aware, early on in the study, of conflicts and jealousies between different factions of women, and for the need to avoid, so far as possible, compounding problems of this nature. Thirdly, as the researcher began to understand the social context of these women's lives, it seemed important to somehow "overview" the social organization of the women in the village and the clans of which they were a part (by meeting and interviewing women from every part) since this would elucidate much of what had already been learned.

For all these reasons then, a second phase of the study was initiated, during which time 69 of the 76 (91%) village women were interviewed. Using data collected during the first phase of the study as a basis, an interview guide was formulated (see Appendix 1). With the help of the chief's wife, a complete list of the women in the village was compiled and interviews scheduled with each one. This list included all women aged 24 and over and those under 24 who were either married or had children. This meant that a small number (roughly 6) between 18 and 24 who were unmarried and childless were not interviewed. Although it is recognized that interviewing them may have added an interesting dimension to the findings, including them may well have jeopardised the researcher's reputation since discussing certain matters, particularly those pertaining to contraception, with young single women would be perceived as inappropriate. Particularly in rural settings in Vanuatu, knowledge and availability of contraceptive methods for young single people is quite a politically sensitive issue⁵.

By the time the second phase of the study had been completed, the body of data had broadened and deepened considerably. A further five interviews were conducted with some key informants in order to expand upon, clarify, or

verify particular findings. After this no further interviewing was considered necessary. The sample, meaning, in this case, not just the number of people interviewed but the number and depth of interviews, was considered adequate using the criteria outlined by Morse (1986). That is, the descriptive account had no major gaps, the account was making logical sense (i.e. it was coherent), and negative cases (informant accounts or events which the ethnography could not account for) were no longer being located. It cannot be said that every aspect of data collection was fully saturated but this was, to a large extent, because the scope of the study was very broad. In so far as there were no major gaps in the descriptive account and the data collected had considerable breadth and depth, answers to the four guiding questions could now be formulated.

Validation of the descriptive account by informants themselves, as well as secondary informants, is also said to be an important means of assuring the sample adequate (Morse 1986). In this study, the researcher was able to verify particular findings by checking and rechecking information with the village women themselves. When informants were not able to validate previous "findings", i.e. they found them confusing or thought them untrue, this indicated a need for further interviews and observations (more sampling) in order to move more deeply into the area under investigation and better illuminate the behaviors and beliefs involved. On the other hand, when informants were able to verify previous findings, and certain behaviors and attitudes were quite similar across several informants (or if different, explainable), the sample was considered as approaching adequate. Secondary informants were also important in validating the account and thereby ensuring adequacy of sampling. Secondary informants for this study included Ni-Vanuatu (one, a woman who was raised in Nasilar but later relocated to a larger center, and the other, a man employed by the central government who worked in the health field and was familiar with the Malekula area), as well as two expatriotes who had each spent some years working in rural Vanuatu.

Interview Format

Interviews with key informants were initially of a relatively unstructured nature. Such broad openings as "Tell me, how is the life of the women in this village?" or "What things can cause sickness here?" were used to initiate conversation and provide a wide scope from within which to identify particular themes or concepts for further pursuit. This, it was felt, was important in terms of minimizing the imposition of a predetermined frame of reference as a basis for questioning⁶. Although this open-ended approach proved fruitful with a few informants, it was more often the case that even open-ended questions of this nature elicited

simple, positive or negative responses. This, it is suspected, was partially because the women found these sorts of questions, at least as initially posed, rather abstract and hypothetical. A much more fruitful approach, it was found, was to begin by asking informants to describe past events (i.e. to give their life histories or histories of past health/illness experiences). By using this to open the conversation and facilitate dialogue, informants themselves often became more directive, steering the conversation to personal worries or health-related concerns pertaining to themselves and their families. This was partly because they understood my work as pertaining to "health", and seemed to feel that as a nurse, a woman, and an outsider, they could reveal their concerns to me⁷. One informant, for example, spent most of the time talking about her concerns for her daughter who was chronically beaten by her husband. Another, about her desire to use contraception and avoid future pregnancies. Using these unstructured questioning techniques, the researcher was gradually able to identify some underlying themes of relevance to health (i.e. gardening, reproduction, kinship), as well as certain behavior and attitude patterns (for example, preferences for and uses of certain healing modalities). It then became possible to be more directive in the interviews so that areas of relevance to these themes and patterns, and the four guiding questions, could be further explored.

By the time the first phase of the study had been completed and the data analyzed, the researcher had enough information to formulate the more structured interview guide (see Appendix 1) to use in the interviews that were to be conducted with all of the village women. This guide was used to focus and direct the interviews but was not intended as a means to survey (in the traditional quantitative sense); that is, it facilitated discussion around some of the themes and patterns that had been identified during the first phase of the study, but also allowed informants to focus and expand on those questions that most interested them and to skip-over those they found difficult or uninteresting. At the same time, a few questions (for example, section C: 2-3 or section F:2) were very structured requiring only a nominal response. Since almost all informants answered these, the researcher was able to tabulate the responses to these numerically. This made it possible to supplement the more narrative account with some simple descriptive statistics in order to give an indication of the generalizability of some of the findings within the village setting (obviously not beyond it).

Formal interviews⁸ were of variable length and ranged from about fifteen minutes to three hours. The longer interviews often took place when the researcher accompanied women to work in their gardens and were conducted "on and off" during the natural breaks of the workday, i.e. during rest times or dinner. Almost all of the formal interviews that took place during the second phase of the study (those

for which the interview guide was used) took place inside womens' houses or sitting on mats just outside. This allowed the researcher to interview the women individually in their home environments, which was of some importance in allowing them to feel comfortable and in control. Almost all of the formal interviews (conducted during either the first or second phase of the study) were tape-recorded; out of a total of 86 noted in fieldnotes, 81 were tape-recorded. In addition to these, there were also some more informal, shorter but significant chats that took place more incidentally while planting yams, for example, or carrying firewood. In these cases, it sometimes wasn't possible to tape-record the conversations but the data, as close to verbatim as could be recalled, were entered into fieldnotes immediately thereafter.

All interviews were conducted in Bislama. Bislama is a form of pigeon English spoken throughout Vanuatu, a lingua franca which allows communication between 110 distinct language groups. Although it draws heavily from English (and, to some extent, French) in terms of its vocabulary, it's grammatical structure and word usage is, to a large extent, Melanesian. As such, it is also reflective of some Melanesian concepts and cognitive categorizations. On north-east Malekula, most adults are fluent in Bislama. In Nasilar, although women usually conversed with one another in the vernacular, they also commonly used Bislama, particularly in more formal settings (i.e. during their weekly church women's group meeting) or when speaking with people who were not fluent in the vernacular (there were, for example, a few women who were from other language groups but had married and come to live in Nasilar). They also listened daily to national radio which was broadcast in Bislama. The researcher had a period of six months in Vanuatu to learn Bislama well before entering the research setting.

Although it would have been ideal to conduct the study using the vernacular, the time required to learn the language made this unfeasible. It could also have been conducted in the vernacular using an interpreter, but it was felt that this presented more disadvantages than advantages, the main one being that the researcher would be unable to detect whether the questions and the responses were being accurately translated. Although Bislama is a very simple language with a limited vocabulary⁹ and it was initially seen as rather limited for obtaining detailed and specific information, it was actually found to be quite adequate once learned proficiently. This made the whole aspect of interviewing much less complicated and within the control of the researcher than it would have been using an interpreter.

As noted, interviews were tape-recorded. They were then reviewed, usually on the same day, relevant portions being transcribed for further analysis. This was, particularly in the early phases of the study, very time-consuming since large portions of the interviews had to be transcribed, the

researcher having not yet identified particular patterns or themes to focus on.

Participant Observation

Following the classification scheme set out by Gold (1969), the researcher in this study took a role that is best described as that of "observer as participant", wherein the researcher both participates and observes but the relative emphasis is on the latter. During the eight months of fieldwork, the researcher visited the village at least two to three times per week (for three to six hours each time), usually starting in the early morning, in order to observe the daily life of the women and to conduct interviews. On some occasions, the researcher stayed overnight in the village, went for the evening, or arranged to be present for events of special relevance to health or to women. It was seen as important that observations encompass varying times of the day and the week in order to ensure representativeness.

Particularly during the first phase of the study, observations included the everyday activities of women such as cooking *lap-lap* (traditional food), caring for small children, working in the garden, cutting and carrying firewood, hauling water, washing clothes, and weaving mats. The researcher also attended the weekly meetings of the two women's groups in the village, the "Presbyterian Women's Missionary Union" which met for a devotional and work activity on Tuesday mornings, and the "Women's club" which met to do handicrafts on Fridays. Later on, observations also included some special activities of relevance to health such as traditional healing activities (i.e. *holem bel*) and the monthly visits of the MCH (Maternal-Child Health) team. Some social events, for example the village New Years Eve party, were also attended.

Early in the study, when observations had to be fairly broad and yet detailed, Spradley's "descriptive question matrix" (Spradley 1979, 82-3)¹⁰ was used as a reference to help ensure that maximal (so far as possible) breadth of information was consciously being taken into account. Shorthand fieldnotes were entered into a logbook during or following each visit and, within the day, entered into a computer file. Although the fieldnotes were initially of a very general nature (describing the village setting, the appearance and behavior of individuals, food, gardens, and so forth), they gradually became more focused so as to address the guiding questions outlined earlier and the particular themes and patterns that emerged in this regard. It was seen as important from a methodological and epistemological standpoint to make sure that the data obtained from observations were clearly distinguishable from interview transcriptions. As Werner and Schoepfle (1987) point out, while the former represent an etic and

potentially ethnocentric account of what is observed, the latter provide the basis for an internal view of the culture, in so far as they are products of the natives' minds. The same authors continue to explain that during the course of the fieldwork, the gap between the observations of the researcher and the informants' comments will narrow, ultimately leading to the best approximation of the internal view of the culture.

V) Data Analysis

In ethnography, data analysis occurs almost simultaneously with data collection. The relationship between the two has been described as a reflexive, even dialectical one in so far as data analysis and data collection constantly feed into and transform one another (Hammersley and Atkinson 1989). In this study, the particular data collected determined, to a large extent, the sort of analysis that could take place, while the analytical findings (i.e. the particular themes and patterns that emerged in the course of the analysis) directed and refocused the process of data collection. In addition, inconsistencies and potential sources of bias that were identified during data analysis could then be examined and then dealt with in the ongoing process of data collection.

The first step in data analysis was for the researcher to immerse herself in whatever data had been collected through a careful reading of it. Several ethnographers have emphasized the importance of this as a first and ongoing step since it allows the researcher to attend to recurrent statements, action modes, and themes (Leninger 1987; Hammersley and Atkinson 1989). After being in the study setting for about three months, it was possible to begin identifying the latter and then to begin to sort, code, and classify data accordingly. The classifications utilized at this stage were fairly broad and tentative so as not to prematurely narrow the focus of data collection. They corresponded to a variety of topics and themes including, "reproductive concerns", "gardening", "traditional health interventions", "marital transactions", and so forth. Initially about twenty files were in use but as the study progressed the files narrowed to about ten, which were later subdivided again (for example, the section on "traditional health interventions" had to be subdivided a further five times). Although it would have been ideal to use only emic categorizations (i.e. those reflecting indigenous concepts and using the language of the informants themselves) to classify the data collected, the level of knowledge acquired by the researcher did not make this possible. So although the information collected was "emic" in nature, the way in which it was classified reflected, to a large extent, categories and conceptualizations of a more etic nature. Although ideally ethnographies should be as "emic" as

possible, realistically, as Robertson and Boyle (1984) point out, most involve a combination of both emic and etic components.

Checking and rechecking hunches and hypotheses with information from interview transcriptions and ongoingly with informants was, as mentioned earlier, also an important part of data analysis. This, as Werner and Schoepfle (1987) note, is important in minimizing the development of an account that is ethnocentrically biased by the researcher. Identification and examination of inconsistencies in the data base was also important. For example, the accounts of different informants with regard to the same health phenomena sometimes did not correspond¹¹, and sometimes the researcher identified discrepancies between verbally expressed beliefs and observed behavior. With time it became obvious that these were not necessarily indicative of methodological error but rather could serve as "epistemological windows", that is sources of insight into the native world (Werner and Schoepfle 1987). Sometimes, for example, such inconsistencies revealed the gap between perceived "correct answers" and deeper underlying values and interests (i.e. some women verbally articulated the importance of preparing meals for their families which included the three food groups, while, by their actions, indicating that getting work done in the garden was a much higher priority).

Gradually, as the data base increased in density, particularly during the second phase of the study, the researcher was able to describe more extensively the particular health-related beliefs, meanings, values, and behavioral patterns that characterized this group of women and to provide an account that could answer the guiding questions initially delineated. This account (given in chapter 7) constitutes what would probably be classified as a "thin" ethnography with some "thick" (analytical) features interwoven. A "thick" ethnography does not merely describe a cultural group in a broad, relatively superficial manner, but ultimately addresses the underlying question: "What social meanings and cultural biases lie at the base of social action?" (Morse and Field 1985, 22). In the case of this analysis, there is an ongoing attempt to relate observed health behaviors, stated concerns, and explanations to the underlying social and cultural features of the society, the explication of which is essential to understanding them.

Returning then, to the original research concern, the final phase of the analysis (see chapter 8) involves examining this descriptive account as a response to the four guiding questions delineated earlier and thereby as a context against which to evaluate the viability of the PHC model. In effect, in this final phase, the first and second columns of Table 1 are juxtaposed and compared. The more theoretical discussion that then ensues draws on insights from sociology of knowledge, as well feminist theory, in

order to make sense of the study findings by situating them in their larger social context.

VI) Ethical Considerations

Although there were no direct benefits for women participating in this study (i.e. material or monetary gains), the project will hopefully benefit them in indirect ways. Firstly, a study report (a report containing the findings found in chapter 7 of this document) was submitted to the Vanuatu Department of Health in February of 1993. It is hoped that the submission of this document will contribute, if even in some small way, to better aligning health and development planning with the felt needs of women. Secondly, many women who were interviewed used the opportunity to obtain health information or to discuss personal health problems with the researcher. In this sense, participating in the project had some educational benefits. Thirdly, it is suggested that many women who may have initially felt shy or lacked confidence with regard to participation, not only enjoyed expressing their thoughts and opinions, but also felt affirmed and validated in the process of doing so (in so far as they saw that their thoughts and opinions were taken seriously and considered important). To the extent that this was the case, the study will have also contributed to the empowerment of local women (individually and collectively), particularly by increasing their confidence in identifying and addressing their health-related concerns.

Although there was minimal risk of direct physical or psychological harm for individuals participating in this study, there was some risk in terms of psychological vulnerability. Some women, for example, would have had misgivings about being observed, about being interviewed on personal matters, or about communicating thoughts and beliefs that were, to their minds, liable to be misunderstood or critically evaluated by a non-native. It was here that the ethical standards of privacy were important so that the community and individuals within it maintained the freedom to decide where, when, and to what extent their beliefs, thoughts, and experiences were communicated to others (University of Alberta, 1985).

At the national level, permission to conduct the study was obtained from the Health Information and Research Committee of the Department of Health, as well as from the National Planning and Statistics Office in March of 1991. At the local level, as noted earlier¹², verbal informed consent was obtained from the village women as a group. Verbal informed consent was also obtained (and tape-recorded) from each individual informant before interviews were conducted (since the majority of these women had only some primary education, written consent was untenable). At this time, each woman was again told of the rationale for the study,

the methodology involved, and the expected uses of the study findings. The tape-recorder was shown to each woman and her permission was asked with regard to being tape-recorded. Each informant was assured of confidentiality and anonymity; she was told that the cassettes would not be shared with others but would be used only by the researcher to aid in recalling what had been said. She was also assured that neither her name or the name of her village would appear in the final report. The researcher also made it clear that during the interviews, informants were under no obligation to answer every question were they to find there were some things they would prefer not to talk about.

It is possible that the women may have felt pressured to participate in the study because of the researchers association with the health department and the women's affairs officer, despite the attempts of the researcher, particularly during the initial meeting with all village women, to make it clear that participation was a completely voluntary matter and that other villages could be approached if Nasilar woman were not interested. In actual fact, although the women as a whole agreed quite enthusiastically to participate, there were individual women who declined. Although none declined verbally (at least to the researcher), there were a few who did so non-verbally by being absent (having gone to the garden) on the day of their scheduled interview. Of those who participated there were also a few who declined discussion on some matters, but again this was usually done indirectly, i.e. by claiming to have no knowledge or opinion with regard to a given topic. Although these women were few in number, they do illustrate the fact that women had ways of declining participation if they so desired. An important ethical role for the researcher was to accept and affirm the choice of these women, despite the fact that some of the women's leaders expressed disappointment towards those individuals who chose not to participate.

At the end of the study, the researcher held a formal meeting with the village women to present the main findings of the study for their review and to thank them for their participation. Although the women seemed to appreciate this gesture, it was difficult for the researcher to obtain validation on more than a few of the major points in the completed report, since by then it was quite comprehensive as well as abstract in some parts, requiring more time and attention to validate than most women were interested in giving. (In fact, uninterested in discussing the whole report, the women seized the opportunity to discuss again with the researcher various methods of family planning). A few weeks later the women organized a feast for the researcher and her family as a way of expressing their appreciation.

VII) Issues of Validity and Reliability

Validity

In quantitative research, various measures are taken to ensure the validity of tests and instruments as measures of the phenomena being studied. In qualitative research however, the main research instrument is the researcher herself, using her skills of interviewing and observation. In this case, the term "validity" is better applied retrospectively to the data that has been collected. For one thing, the findings, in this case the resulting descriptive account, must be verified by informants as an accurate description of their way of viewing the phenomena at hand (Spradley 1979). As previously noted, in this study, village women themselves, as well as secondary informants, were involved in validating the descriptive account. Although secondary informants were able to read and assess the final written product, for primary informants (the village women themselves) this represented an untenable ideal, given that it was written in English at a post-secondary level. It was much more feasible to obtain their validation for smaller portions of data at a time, as an ongoing part of data analysis. Indeed, as Robertson and Boyle (1984) emphasize, the fact that data collection and data analysis go on almost simultaneously in qualitative studies is important in ensuring the validity of the findings; any discontinuities, contradictions, or puzzling features that might point to errors in the emerging descriptive scheme can then be addressed in subsequent interviews. Other factors that help to establish the validity of the study findings include the fact that behavioral observations supplemented interview data, that the researcher spent a relatively long period of time in the study setting (over a year on Malekula island), and that data analysis was both intensive and extensive (Robertson and Boyle 1984).

Although the researcher became proficient in Bislama, the fact that it was still a new and not entirely mastered language¹³ meant that language represented a potential threat to the validity of the findings. However, tape-recording the interviews meant that they could later be reviewed so that lost points could be recovered and any ambiguities sorted out with the help of books (i.e. bislama dictionaries), other bislama-speaking people, or subsequent interviews.

Representativeness and Generalizability

As noted earlier, the objectives of this study and the methodology employed meant that a high priority was placed on obtaining information of a rich and meaningful nature and less on attaining findings for which representativeness and generalizability could be scientifically assured.

Nevertheless, questions as to the representativeness and generalizability of these study findings are important to address.

In qualitative studies, any informant belonging to a specific cultural group is assumed to represent that group and the findings of a good ethnography are assumed to have *some* "fit" in related contexts (Sandelowski 1986; Denzin 1978). Rather than focusing on representativeness in sampling however, the qualitative researcher considers representativeness, or more specifically the dangers to representativeness, at the time of data analysis: the researcher must, for example, discern the typicality or atypicality of observed events, behaviors, and responses. Sandelowski (1986) notes that failure to do so can result in "elite bias", in which case stories of key informants (who are frequently articulate, accessible and higher-status members of their group) are overweighted rather than placed in their proper perspective, or in "holistic fallacy" wherein data are made to look more patterned or regular than they really are (Sandelowski 1986). The researcher was attentive to these dangers in so far as a wide range and large number of women were interviewed and observations encompassed a variety of times and places.

As noted earlier, there were some questions included in the formal interview guide which were systematically asked of *all* women interviewed (the responses to which could be tabulated numerically) and representativeness in the case of the data obtained from these particular questions is obviously very good (since over 90% of the village women were interviewed). However, the majority of the data were collected in a more qualitative manner and the above paragraph discussing the importance of checks on representativeness in the context of qualitative approaches is of greater relevance for the study as a whole.

If the findings of this study then, can be said to be reasonably representative of the women in Nasilar, how generalizable are they further afield? Obviously, in the traditional scientific sense, the methodology employed in this study does not permit the researcher to make any generalizations beyond the village setting. However, common sense would suggest that in so far as women in Melanesia do share many common cultural characteristics, lifeways, and circumstances, the findings of this study will have some "fit" and therefore relevance in other village contexts, certainly within Vanuatu, and quite possibly also further afield.

Reliability

Reliability, which is usually taken to be a necessary precondition for validity, is more difficult to ensure in qualitative research. This is because techniques for gathering data are highly individualistic (in this case involving an intermingling of unstructured interviews, semi-

structured interviews and observations) and one is less able to prove that a subsequent study using the same research method would yield a similar result (Robertson and Boyle 1982). Guba and Lincoln (1981) suggest that in qualitative research "auditability" should replace reliability. "Auditability" is present when another researcher can follow the "decision-trail" used by the investigator and also when it is felt that a second investigator could arrive at a comparable conclusion given the same research data and situation. To make auditability possible, detailed documentation of the research process is important, including the manner in which the data are collected, categorized, and analyzed, as is the availability of the original (raw) data obtained from observations and interviews. In this study, original tape-recordings, transcriptions, and fieldnotes were kept, as well as copies of the data at various stages of coding and analysis. All of this helps to ensure that the study is auditable.

Footnotes

¹Although it might have been ideal to organize the sections of the ethnography so as to chronologically answer each of the guiding questions, it was seen as preferable to organize the account so as to maximally facilitate understanding. For example, some sections of the ethnography were closely related and built on each other and were, therefore, best presented in sequence despite the fact that this meant the guiding questions were not chronologically answered.

²Interviews were conducted in Bislama, a form of pigeon English. The use of Bislama is discussed later on.

³"Saturated" is a term used in qualitative research. When the data are not saturated this means that there are still a lot of "blank spaces" in the account and there is therefore still a lot of new information to collect. When one is no longer collecting any new information, then one can assume that the data are saturated. See Morse (1986).

⁴This is another kind of sampling sometimes used in qualitative research. In this case, the researcher has informants suggest friends or others who they feel could also provide useful information for the study. These individuals then become informants and these, in turn, suggest others (Morse 1986).

⁵I heard, for example, about one occasion when a nurse had come and given a talk on "family planning" methods. Apparently the younger single women who were present were asked to leave.

⁶This is relatively speaking. It is recognized that it is impossible to come into a study situation as a "blank slate", that one always uses, to some degree, a predetermined framework.

⁷Admittedly, this had also some disadvantages which I had to attempt to "off-set", for example women telling me what they thought a "health" person might like to hear.

⁸There is obviously a range of verbal interchanges, all of which can provide data, from the shortest and most superficial to the longest and most intense. Obviously it wasn't possible to tape-record all of these. Therefore I arbitrarily consider a formal interview an interview which was usually prearranged, the main purpose of the exchange being to interview, as opposed to a shorter less formal chat that was incidental to another task.

⁹One is, for example, very dependent on context in order to discern which of the many possible meanings of a particular word is intended.

¹⁰This is a matrix that the researcher can use to ensure that observations have been as complete as possible. Its plots nine dimensions (including space, object, actor, activity, and so forth) along horizontal and vertical axis which give rise to eighty-one questions that can be used to check and recheck the thoroughness of one's observations and recall.

¹¹For example, see the section in chapter 7 on domestic violence.

¹²For details, see section on "Setting: Access and Entry", earlier in this chapter.

¹³It was its more subtle and context-dependent features that were hard to master.

CHAPTER 6

THE STUDY SETTING: NASILAR VILLAGE

The Village

The village in which this study was conducted will be referred to as Nasilar. To reach it, one follows the main road that runs north along the coast of Malekula, passing through several miles of coconut plantation initially and later through lush tropical forest. The road wends its way through some narrow valleys, and crosses two creeks (which quickly become rivers in a heavy rain) before reaching the Nasilar turnoff. Usually one or two "pickups" or "mini-buses" are met along the way and small groups of villagers can be seen walking along the roadside to their gardens. The early morning drive is a pleasant one; the sun, still low on the horizon, pokes its bright light through the dense foliage and the air is fresh and cool.

A two-track lane to the east leads off the main road into a large open grassy area, to the left of which is the Nasilar Presbyterian Church. The church is a very plain old wooden building, sun-scorched, its white paint peeled. It is the main meeting place for the villagers and the center through which modern village life is organized. Just behind it is the pastor's house, and to the right, the chief's, the two *bigman* ("big men"¹) of the village, as one informant told me. Behind these, is the central village area. Here one can see several jagged rows of closely-spaced *kastom*² houses, that is traditional houses with walls of woven bamboo and roofs of *natanggura*³. There are also several with roofs, and in some cases even walls, of corrugated iron, a sign of relative affluence. There are seventy-six households in the village, but only about forty of these are located in this central area; the others are clustered in small family groupings a short distance away. According to the chief's census last year, there are about 375 residents⁴.

The main village area is centered around two large *natora* trees, in front of which a wooden stage has been erected for community functions. Off to the side is an open well and in the distance, just beyond the last row of houses, one can see the coral beach and the glistening aqua blue of the ocean. Several bamboo shelters have been erected along the beach and in the late afternoon especially, it is common to see women and children resting there, or sometimes groups of men "storying"⁵, enjoying the cooling ocean breeze whilst protected from the sun. Some traditional outrigger canoes lay overturned on the beach as well and sometimes there are toddlers playing in the water, especially if it's high tide. There isn't a lot of recreational swimming though, partially due to fear of sharks.

The village has a face of idyllic peacefulness. Especially on weekdays, like this, there is not a lot of visible activity. And it is mostly quiet; the odd rooster

crowding, the rhythmic sound of coconuts being grated, some laughter in the distance.

The houses are arranged according to family groups. Although in almost all cases each nuclear family has a separate dwelling, that is minimally a house in which to sleep and one in which to cook (the "kitchen"), most live in close proximity to the husband's father or brothers, the area being patrilineal and patrilocal⁶. Inside the houses, furnishings are minimal; one or two woven grass mats strewn over the coral, sometimes a foam mattress on which to sleep, a mosquito net, a kerosene lamp for night, and an outdated calendar or some other wall decoration. Inside each kitchen is a fire pit lined with black stones (which are indispensable for traditional cooking), one or two heavy iron cooking pots, and a few plates, spoons and cups. Sometimes a big bag of rice, some yams, or some coconuts will be visible in the corner of the kitchen, but generally food isn't stored indoors for long periods.

The villagers use a vernacular which is shared with other coastal villages on North-East Malekula⁷ (although almost everyone is also fluent in Bislama). The original inhabitants of Nasilar settled several generations ago, moving down to the coast from further inland because of tribal fighting. With time, other tribes followed, coming under the jurisdiction of the original chief. Each tribe had its own "small" chief and its own *nakamal*⁸, the meeting place of men around which the social and political life of the group was organized. Today there are five *nakamal* in the village and although the villagers have all intermarried so that literally everyone is "family" with everyone else, their strongest sense of identity continues to derive from the clan of which they are a part and the *nakamal* with which they are associated.

In modern times, the chief, the pastor, and the elders are the most important leadership figures and considered to be the *bigman* of the village. They often meet to discuss village matters and are responsible for sorting out conflicts and dealing with internal problems. The elders, of which there are seven, are the church elders as well as the village elders. They are all men, said to be chosen by the community on the basis of their Christian conduct and character. Once installed, they are elders for life, unless dismissed for reasons of misconduct. The chief is selected on customary grounds (he either inherits the position or is elected through a democratic decision-making process involving all village men in the *Nakamal*) but is brought into the church and prayed for as part of his inauguration.

Most ongoing village activities are organized through various committees, most of these being part of the church infrastructure. There is, for example, a youth committee, a women's group committee, and a board of management committee, as well as committees pertaining to sports (i.e. volleyball, football). There is also a disaster committee which, in the case of cyclones, submits a report of the

damages to the local government council. A village committee with responsibilities pertaining specifically to health has never been formed. There was a water supply committee in existence three years ago when, for a short time, the village had a functioning piped water system. The system is no longer functioning, however, and the committee has long been dissolved.

Every household in Nasilar has access to land and almost everyone plants copra and cocoa in addition to their domestic gardens. A few families have livestock: seventeen are reported to have cattle (usually one or two head) and there are five families who own horses. There are three men in the village who own trucks. A few families are active in business: one, for example, owns a chain of small stores which sells domestic goods such as tin foods, sugar, rice, and kerosene. Another runs a "nightclub". In the case of the latter, a large traditional building had been erected by the side of the main road and people (the majority of which are men from neighboring villages or further afield) congregate there on Friday nights to dance and drink.

The villagers sometimes travel by "mini-bus" to Norsup and Lakatoro which are the main administrative centers for the island. The buses charge 100 vatu (about one Canadian dollar) for the twenty minute drive each way and even though some villagers complain about the cost, it does not seem to be prohibitive. Some frequent Norsup in order to go to the stores (there are three or four that offer more variety than the local ones) or to sell their produce at the market. Others go in order to visit the district hospital which has an active outpatient department. Although there is also a government dispensary not far north of Nasilar, most villagers choose to come to the hospital, as transport is not a problem and the quality of care is considered to be higher.

The Everyday Life of Women

For the women in Nasilar, the day begins early. Not long after the roosters have started crowing and the sun has begun glowing red on the horizon, they are up carrying kindling and firewood into their kitchens. As each fire is lit, a grey stream of smoke curls upwards into the morning air. Some women can be seen returning from the well; each has a long piece of bamboo balanced across her shoulders with plastic buckets full of water suspended from each end. Water will be heated on the fires for tea, the remainder used later for washing dishes and other household tasks. The children mustn't be late for school: their mothers hurry them to wash and eat, and pack their lunches for them, usually rice or *lap-lap*⁹ bundled in banana leaves.

With the children off to school, the women have a chance to eat breakfast or even to steal a quick nap. But most are anxious to complete their morning chores so that

they can set off to the garden and get a good portion of work done before the sun gets too high in the sky.

First, there is the housework. Grass mats are taken outdoors to air and the floor is swept with a broom made from the stems of coconut leaves. Next the dishes, which are usually few in number, are washed just outside the kitchen and placed on a wooden rack to dry. Iron cooking pots are taken down to the nearby beach where the sand is used as an abrasive for scrubbing. Then the family's clothes are washed; they are submerged in a large tin basin of soapy water, scrubbed vigorously with a bristle brush against a wooden board, wrung out by hand, and then hung in the hot sun to dry. Some women prefer to carry their washing to a location nearer the well itself in order to avoid walking back and forth with heavy buckets of water. But most prefer to wash nearer their homes, usually choosing a cool place under a shade tree. The animals have yet to be fed; old coconuts and other leftovers are carried to the pigs, most of which are fenced just outside the main village.

The women move and work at a pace that is steady but not hurried; there is time to chat with a neighbor who is passing by, to ask her about her plans for the day, to "story" a little. For those with infants and young children, there are many interruptions and the work progresses more slowly. Sometimes a young girl or a grandmother will look after a baby while his mother works. Other times the baby is fastened comfortably to his mother's back while she goes about her morning's activities.

Once the housework is finished (or sometimes before—especially if it is planting season), the women are off, bush-knives in hand, to the garden. They are usually accompanied by two or three other family members or sometimes by their husbands. Typically, they are barefoot and dressed in their oldest, most tattered, "island dresses"¹⁰ now relegated to garden use. The latter usually forms a second layer of clothing protecting another dress worn beneath, and under this, a layer or two of shorts, lest one be exposed by a sudden gust of wind.

Some gardens are as close as five minutes walk away, others as long as one and a half hours depending on the location of the family's *graon* (land), that is the husband's family's *graon*. Each extended family will have a large section of land which will have been parceled off, an area designated to each of the sons. Hence it is often sisters-in-law who are seen walking together to do the garden work. Unmarried women work in the gardens of their parents until they marry and go to live with their husband's clan.

The women appear to enjoy the walk to the garden, smiling and talking, swinging their bushkives to remove obstructive vines as they go along. There is a creek to wade; the clear cool water is a welcomed tonic in the hot weather. There are usually several stops along the way; to check another family member's garden, to collect banana

leaves, to carry some vegetables or fruit to transplant in another location.

During planting season (roughly July to December), gardening work can be quite intensive and the women will spend up to six days of the week in their gardens. Women with young babies, and a supportive extended family, can sometimes leave the gardening work for others until the baby is at least a few months old and can be more easily carried to the bush. Likewise, especially if the garden is quite a distance away, small children will sometimes be left in the village under the supervision of a relative. But often small children go along to the garden as well, tied in a *kalico*¹¹ to their mothers' back or trundling along side. If possible (sometimes, because of schooling, it is not) young girls of the extended family will come along to look after children in a shaded area while their mother works. Girls of only ten or eleven can be quite adept at caring for their younger relatives; entertaining and supervising them, finding food for them, making fires and cooking for them.

Garden areas must be cleared and burned, then there is the planting, tending, and harvesting. The women plant traditional crops such as yam, taro, banana and island cabbage, although they also plant vegetables such as tomatoes, onions and cucumbers which are popular for selling at the market in Norsup. Some of the planting is not difficult as the foods are found naturally in the environment and require only transplanting into the garden area. For example, planting island cabbage involves only loosening the soft black soil with a spade or a bush-knife and then gently inserting the branches into the ground and packing the dirt around them with one's feet. Planting yams however, can be very hard work. For some yams, a circular hole has to be dug, almost 2 feet in depth. For this, a heavy iron bar is used to loosen and break-up the soil, which is then scooped out by hand. The person pounding usually takes several rests, leaning against the bar, wiping the sweat from his or her brow. One woman told me that she sometimes planted up to fifty yams in one day.

There is no longer a strict division of labor when it comes to gardening work; men or women can perform any of the required tasks although it is thought most appropriate for men to do the heavier work such as clearing the garden areas or digging the holes for the yams. Although some men, it was observed, did undertake these heavier gardening tasks, several women complained that on Malekula women often did the work of men, performing much of the heavy work themselves.

Although the main purview of the women is seen to be domestic gardening, they are often expected to help out with the cash crops as well, particularly with copra. Shelling-out copra involves gathering coconuts into piles, splitting them open with an axe or bushknife, and prying out the contents (the oil-yielding kernels or "copra"). The copra is then dried in a large bin over a fire, put in gunny sacks,

and sold to the "middle-man" who ships the product off to the city of Santos¹². Women stated that shelling out copra, and carrying the heavy gunny-sacks, was very tiring work and that they much preferred working in their domestic gardens.

Although women often spend the full day at the garden (or nearby in the copra grove), they seldom need carry anything to eat or drink. Bananas, paypayas, and other fruits can usually be found in the garden or nearby in the bush. At noon, they usually make a fire on which taro, corn, or banana are roasted. When thirsty, a long piece of bamboo is used to prod and dislodge green coconuts from the tops of the coconut trees. Banana leaves, which grow abundantly, are used for a multitude of purposes; to sit on, as plates for eating, to provide shelter from the rain, and to wrap garden produce in. Barring cyclones, the bush is a place of abundance, and despite the hard work of gardening, not an unpleasant place to spend the day.

In the late afternoon the women can be seen returning from their gardens laden with vegetables, fruit, banana leaves, and/or firewood. Sometimes their heavy loads are fastened to their backs with *kalicos*, other times the goods are wrapped in leaves and vines and suspended from a long stick of bamboo which is carried between two women. Sometimes the women's husbands are with them, also carrying a heavy share of garden produce. Other times the men return to the house separately - from working on the cash crops, fishing, or sometimes from just "storying" with other men.

Not long after returning home, the women start preparing the evening meal, which is almost invariably¹³ *lap-lap*, the traditional mainstay. Yams and coconuts are grated, the fires, on which the cooking stones will heat, are lit. Banana leaves and vines, in which the *lap-lap* will be packaged to roast, are carefully laid out. Almost always, I was told, cooking was the work of women, although there were said to be a few men, considered atypical, who did help out their wives from time to time. Women were not allowed to cook, however, during their monthly period, at least not for men. This "taboo" was strongly adhered to and it was believed that carelessness in this regard could cause men illness. During this time, the menfolk of a women's family would eat with other relatives. A menstruating woman was allowed to cook for herself, for other females, and for young boys, but never for men.

Around dusk, the men begin to disappear; it is kava time, when they congregate in the *nakamal* to pound and prepare kava, to discuss, to "story", and then to *lisen*¹⁴ while its sedating effects take hold. Whilst once a ceremonial custom, it has now become a nightly routine for many. Although there are a few women in the village who drink kava from time to time at home, they would never consider entering a *Nakamal* since this continues to be a strictly male domain. Men's kava drinking is accepted by women, quite pragmatically, as a normal part of everyday life; but many complain that it means they have no help with

the children in the evenings, that the men come home late, only to eat and sleep. Some concede that at least its effects are better than that of alcohol.

While the *lap-lap* cooks, some women find time to go fishing off the reef or to sit down with their children near the sea where there is a cooling breeze. Sometimes they can be found in groups of two or three weaving mats; this is a time to relax and socialize together. The mats, which are woven from the dried leaves of the coconut or pandanus tree, are sometimes sold at the market in Norsup but more often, they are constructed for domestic use or as gifts. Traditionally, they have always been important objects of exchange.

As evening falls in the village, kerosene lamps are lit and can be seen flickering behind bamboo walls. Mothers are heard summoning their children from playing outdoors; they need to bathe and, in the modern era, to do their homework. The *lap-lap* is also ready to come off the fire and the hungry children sit down, arranging themselves in a circle around the bundle, which their mother carefully unwraps and lavishes with coconut cream. In some households the father is home by now and the family will eat together; in others he will be out until much later. Not long after eating, the sleepy children settle on their mats for the night. Now their mother's work is complete; wearily she bathes, goes to her mat, and falls asleep.

Footnotes

¹*Bigman* is a bislama term commonly used. It means an important person; one of high social or political status.

²*Kastom* is a bislama term used in a variety of contexts to refer to custom, i.e. to traditional ways of doing things.

³*Natangura* are thatch slabs woven of leaves from the sago palm.

⁴He mentioned that the present population would be slightly higher as several babies had been born since then.

⁵I use the term "story" because the word they actually use in bislama, *storian*, is derived from the english word "story". To *storian* means to visit, chat, yarn, swap stories. It is a very descriptive term and I have chosen to use "story" as its closest english equivalent.

⁶There are sometimes exceptions. For example, a couple may choose to live near a wife's aging parents if there are no sons in the family to care for them, or if there are severe family tensions between parents-in-law and a daughter-in-law, the couple can sometimes relocate in the vicinity of the wife's father and brothers (I knew of one couple where this was the case).

⁷It is used in the area extending from Atchin in the north to Wala, Rano, and Uripiv islands, and south to Potinder on the mainland.

⁸*Nakamal* are common throughout Vanuatu. They are traditional buildings or sometimes designated areas (i.e. under a large banyan tree) that are the central meeting places in the villages. Commonly there is restricted access to them, preventing women, and sometimes men of low status, from entering. Kava, which is a mildly narcotic drink made from the kava plant (*piper methysticum*), is drunk by men in the *Nakamal*. Traditionally, kava was important for religious and political ceremony and in modern times it continues to have to have social, political, and ceremonial importance. In most villages kava drinking is an important part of every day life; every evening men congregate in the *nakamal* to "story" and to drink. Although today some women drink kava, they generally do not enter the *nakamal* in traditional village settings.

⁹*Lap-lap* is a traditional dish, a sort of starch pudding made from tuber (root crops). Usually yam, taro, or banana is grated, mixed with coconut milk, wrapped banana leaves, and then placed on hot cooking stones to roast.

¹⁰Island dress, or *aelan dres*, as said in Bislama, is the name for the Mother Hubbard dresses introduced by the missionaries during the nineteenth century. They are commonly worn by women throughout Vanuatu. They are colorful loose dresses with lace and ribbon trim.

¹¹This is a bislama term meaning cloth or clothing.

¹²The final product is coconut oil.

¹³There were occasions on which other foods (i.e. rice, boiled taro, kumala, breadfruit) were eaten, but in this village it was common to have lap-lap almost every evening.

¹⁴*Lisen* is the Bislama equivalent of the english word "listen" although it has a much broader meaning. It means to pay attention or "tune into" something, often to bodily sensations. The word is commonly used to describe what men do after they have drunk kava, that is they paying attention or "tune into" its effects (it has a very sedating, quieting effect).

CHAPTER 7

THE STUDY FINDINGS

A) Health as a Priority for Women

They [the women here] work hard, they grow lots and lots of food and they get money for it too...if you try and make them think about health... they aren't concerned at all, they don't think much at all about the sickness that can come, all the women in this village, they don't think about it. They get up in the morning, they drink tea, O.K. they shoot for [go directly to] the bush and work till its dark...all the mothers in this place, they don't think seriously about health...the nurses come and talk about the many bad things that are affecting our health. All the women come out and listen but they don't do anything.

The above statement, made by one informant in this study, encapsulates well the situation and sentiments of Nasilar women. Women were found, in general, to have little time for or interest in health-related activities such as attending health education talks, participating in village health initiatives (such as cleaning the village and cutting the grass to decrease mosquito breeding), or even in terms of giving priority to basic nutritional and hygiene needs of children. Of all of the women interviewed, all but a very few said that they felt women were much more concerned about gardening than about health:

I don't think they're very concerned [about health] ...cause look, when you wanted to hold a little health talk in the center, they didn't come, they don't think about this [health], they think about their gardens... some have interest but some haven't...if you talk about this [health], they don't listen, when your thinking is on this big issue here, their thinking is a *long* way off, a *long* way off from anything you might be telling them...its at the garden.

...they think about yam, they think about planting food only...if you talk about health, if you talk about this good thing here (health), what you've been talking about together stays right there where you've been talking about it [it doesn't move or have any effect]...that's it now, all the women go to the bush, carrying their bush-knives, they shoot [go directly] for the bush, now [since the cyclone] they're strong on planting sweet potatoes.

I think they think only about their work in the garden...in the morning...in the morning, they get up,

they go...they don't think first, they don't think about doing anything at the house.

...they forget health--they think only about the garden, cause they want money to buy some things.

Some informants emphasized as well, that the availability of curative services, that is the presence of the hospital, was very important to women, but that they had little time or energy for preventative endeavors such as health education:

...they just come and they listen, then it's over [they don't do anything]. When malaria catches one they fall down...then they think only of the doctor..."take me to the hospital" [they say], "the doctor will make me alright, then I'll come back."

When they go to work in the garden, if they get sick, they have to go to the hospital - but if you try and explain something [about health] so they can understand it, they don't want it! oh...all the women here, sorry!

Some informants commented that women participated in health activities primarily because they felt obligated to come (i.e. to show a good community response) but the motivation to follow through on advice or teaching given was often lacking. Some of the women commented that the only time the village really got cleaned was when Rural Health told them of an upcoming village competition, usually organized as part of the activities of "National Health Week":

When "Health" comes and says "you guys clean up all the villages"...O.K. at this time we clean...but since then there's been nothing at all...the grass grows but...[no one does anything about it]. But if health week comes and we are told that they [the Rural Health staff] will come and visit...that's it, we clean the village--this was last year, this year I think it won't happen [since there is no competition in this area].

If "Health" sends a letter to the chief, it says that next month they will all come and visit, all the women turn up...but *after* they don't worry, its over, its over...

Quotes as to the priority of gardening or going to the bush (the latter being inclusive of domestic gardening as well as helping with cash crops) became replete in the interview transcriptions. Observations recorded in field-notes concurred that most women expended the best of their time and energy on gardening activities and that the health of themselves and their families was considered secondary.

Some women, for example, had young children with severe scabies and who were obviously underweight. While they liked to ask my advice and see if they could obtain medicine from me, often they did not follow through with advice given because of other priorities. For example, although I told them that the day the MCH team came they could come and get scabies lotion, some of them went to the bush instead. Likewise, small children were often taken with parents to the garden and given food that was convenient (i.e. ripe bananas) despite the fact that knowledge about the importance of the different food groups was quite well known and at least two of the three food groups were usually available. There are, of course, a multitude of factors that could explain these behaviors, but the evidence from this study would suggest that the time and energy invested by mothers in gardening activities makes other priorities secondary. Some women stated that they rarely participated in any community activities because of their workload. This seemed to be especially the case with women who had several young children. Leaders of the womens' groups in the village complained that the turnout for women's activities was poor:

I look,... if its our time on Tuesday [for Presbyterian women's group], we ring the bell to go to church, there are only a few [women]. So *where* are all the women that live in this village? ...every one, when they hear the bell in the morning they pass, using another road, and go to the bush..they go to their gardens.

National studies have underlined the important role that women play in terms of domestic and cash cropping and the time and work pressure this means for them, especially in areas like Malekula where, relative to other islands in Vanuatu, people are very active in cash cropping. In 1989, Malekula produced over 28% (the second highest of all islands in Vanuatu) of the country's copra and over 60% of the cocoa (Republic of Vanuatu 1990). These figures are accounted for, to a large extent, by the presence of two large plantations on the island but smallholders (i.e. household units) are also very active in growing and processing copra. According to 1989 figures, 95% of households on Malekula have access to coconuts and the percentage of households to have cut copra in the twelve months preceding the smallholder survey was 84% ,the highest of any island in Vanuatu (Republic of Vanuatu 1990). Women themselves told me that all families in the village grow and process copra. Although these cash crops are considered to be primarily the purview of men, women are expected to help.

Although both men and women are active in domestic gardening, this is considered to be more the purview of women, and although there were some exceptions, most informants felt that they did more work and carried more of the responsibility for gardening than their husbands:

I think that it's all the women now, they do the most work in the garden. Because I look and I see that sometimes a man will just stay at the house, he doesn't think to go to the garden to work or to carry food and bring it to the house...the woman now, she's there and she must think about going to the garden.

In addition to providing food for domestic consumption, many of the women in Nasilar sell their garden produce in the market at Norsup. "This place is strong [keen] on selling at the market," I was told on my first visit to the village, "because it's full of food." The soil is rich and fertile and, barring cyclones, the women are able to plant and harvest a large surplus to sell. This provides a welcomed extra income but also means that their workload is considerably increased when coupled with gardening for domestic consumption and helping out with the production of copra and cocoa. The agricultural census report (Republic of Vanuatu 1986) found that in the Malekula area, higher than average (national average) proportion of time was spent on cash crops by women and a lower proportion of time was spent by men in these regions on food crop production. This means that women on Malekula have an especially heavy workload when food crop production is combined with cash cropping.

Putting "objective" data to the side, however, the motivating factors for gardening that women themselves disclosed were also investigated in the course of this study. It was obvious that women not only spent a significant proportion of their time and energy on garden activities, but that they were also quite internally motivated to do so. Explanations as to the impetus for gardening revealed a number of motivating factors.

Some informants, when asked to explain why gardening was so important to them, seemed to feel that the question was unnecessary and the answer redundant. They explained that having a garden was basic to survival and an important source of security. It meant that they would have food for their family regardless of whether or not they had vatu:

If you have no food, what are the children going to eat?... the life of everyone, it is in food...if you don't have money, but you have food, you'll be alive.

Man is alive because of the garden only...when you get up in the morning, you think only of the garden, you go look for food for the children.

For many informants, the main impetus for gardening was said to be the cash income that one could acquire by selling garden produce. Every Saturday morning before sunrise, several of the women of Nasilar load up their vegetables and fruit, climb into the back of a "pickup", and

are driven to the market in Norsup¹. Although the women have to pay a small fee in order to sell their produce at the market, they report that on a good day they can gross up to 2000 or even 3000 vatu (more often around 1000)². They say that the money they earn is used primarily to purchase items for household consumption: sugar, soap, kerosene, and rice. Sometimes it is also used to help pay for children's school fees or it goes towards community or church projects to which villagers have been asked to donate.

When women were asked to whom the money earned at the market belonged, there were a variety of responses: some said they kept it in their possession giving only a small portion to their husbands so that they could buy kava or cigarettes, some said their husbands demanded all of it, and others simply said that the money was often a cause of conflict between themselves and their husbands. In any case, for many women, it was an underlying worry about money and about their ability to provide for their children that motivated them to work hard in their gardens:

Sometimes they worry...they are thinking about their houses, food, about looking after their children...about finding the vatu to pay for things...this is the thing now that they worry about more than health, they are forgetting about it [health], thinking only about the garden.

We work in the garden cause of the money only - to pay for sugar, kerosene, soap,....these kinds of things.

Although it has sometimes been assumed that the Ni-Vanuatu are sustained by "subsistence affluence" and are not dependant on the cash economy for their basic subsistence needs (at least for food and shelter), north-east Malekula is an area where, because of intensive cash cropping, villagers have become accustomed to purchasing certain imported goods which are now seen as indispensable (i.e. sugar, kerosene, soap). Money is seen as essential to modern village life and gardening one way of obtaining it. Furthermore, for a small group of women, gardening may mean an unprecedented opportunity to gain some measure of financial independence.

This intensification and modification in the role of gardening has not come without causing some conflict and dissonance within the community. One informant spoke with some disapproval of womens' preoccupation with gardening. During planting season, attendance at the Presbyterian women's group always dwindled. "They can't even give up *one* day for this" she complained. She went on to explain that although she too sold vegetables at the market, she had some serious misgivings about the role that gardening and the market were coming to play. She explained that she felt that the best in ones garden should be given to friends; this was the Christian way and if you followed it more blessings

would come to you. She said that many women sold the best of their food at the market and were sometimes, then, even short for their own families. Sometimes, she said, women would come to her asking if she had any spare banana leaves in which to cook lap-lap as they had sold all of theirs. Or worse, when she told them to pick fruit off her tree for their children, they would pick it but take it to the market and sell it.

Although gardening plays its most basic role in providing food and *vatu*, and thereby in meeting basic security needs, it also has cultural and social meanings and functions that extend far beyond this. Although few informants were able to *verbally* articulate the role of gardening in their tradition and culture, the latter became very evident when I accompanied them to work in their gardens. Every informant was very pleased to show me her garden; its boundaries, how it was situated in relation to the gardens of other family members, what had been planted, and how it was growing. It was clear that gardening represented a chance for women to express and display their industriousness and they admitted that there was, as well, an underlying element of competition between them when it came to gardening.

The cultural significance of gardening is also closely related to the significance of *graon*³ (land) in the Ni-Vanuatu context. One's garden is almost always located on one's *graon*, or more specifically one's family's *graon*, which is a highly-valued resource, a source of family identity and pride, transmitted from generation to generation. As Kenneth and Silas comment:

Land is integral to the life of every Ni-Vanuatu. It is a most valued resource since, through it, a person derives not only sustenance but also social prestige and a measure of control, or power (Kenneth and Silas 1986, 69).

In the case of north-east Malekula, *graon* is passed on from fathers to sons, although in some exceptional circumstances it can remain in the hands of a daughter until she has a son to whom she can give it. Although the women, then, retain few land rights apart from through their husbands or fathers, the gardens they so carefully tend and thereby invest themselves in become a part of their identity as well, a means of self-expression and a source of pride.

One informant was able to explain to me that gardening was central to the way of life, more specifically to family life and to the traditional roles of men and women. She explained that if, for example, a young man was not interested in working in the garden, the elder men in his family would reprimand him. They would say:

You must go to the bush, work [plant, tend] some food. If, at some point, you take a woman and she comes to

[live at] your house, she'll have nothing to look after... you must go, if you stay here like this, a woman might come, but what's she going to eat?

Another woman, when showing me her garden and those of each of her children, spoke of her disappointment in her son. He worked on one of the plantations and when he came home on the weekends, never worked on his garden; he went to play football instead. It made her cross that he didn't recognize the importance of gardening. In effect, gardening not only embodies certain values but represents an ethic as well.

Traditionally gardening was also intimately interwoven with custom and religion and, as such, represented an activity that was encompassed within the realm of the sacred. I learned for example, that in former times, traditional singing and prayers (usually directed to ancestors) would accompany the planting of yams. Some informants would offer a Christian prayer before we started the gardening or after we had planted, this perhaps representing a modern equivalent. Gardening was also traditionally governed by various taboos. For example, certain seafoods could not be eaten before working in the garden lest they spoil the yams, menstruating women were not allowed in the garden, and so forth. Although it is not within the scope of this paper to expand on these, it is clear that gardening has a significance that is rooted in traditional culture and has a value that far exceeds its utilitarian function.

Finally, there is another dimension to the role of gardening which a few informants revealed. Although it might appear to contradict what has been said thus far about the apparent internal motivation and enthusiasm with which women approach gardening, it does represent another side of that "motivation". Apparently, some women felt forced, or at least obliged, to take on the gardening work, as they felt this their appropriate role and responsibility given the high brideprice their husbands had paid for them; they were expected (and expected themselves) to work hard and productively because of this. One informant explained it this way:

Sometimes with some women, their husbands don't want to work in the garden, so - they force their wives to go work in the garden - we say now that women are coming up, men are coming up, that the two will be at the same level [equal] ...but in this place, I look, I see that the woman, she is like the slave of her husband or what...I think his thinking is that "I paid *a lot* of money for you"...this is the attitude in Vanuatu just like in other places where they pay for women..."because of the big money with which I paid for you, you must go work in the garden"... that's it now.

This same informant explained that although *her* husband never forced her to go work in the garden, that she, herself, sometimes felt obligated to go for these reasons, even if she wasn't feeling well.

In conclusion, the time and energy women expend on gardening preclude a high degree of investment in activities that are more specifically health-related. One informant summed it up this way:

There's not much worry about health...cause I look, I see that every morning you get up, you carry your bush-knife, you go to the bush - you don't think about your body anymore, you think about the work you're going to do...if you really thought well of your body, then you'd stay at the house and clean up well, only sometimes you'd go to the garden.

The fact that women felt they could not afford to make health a priority did not, of course, mean they had no health concerns. In fact, as some of the subsequent sections of this paper show, informants identified several health issues that they felt were central to improving the life of women and some were quite desperate to obtain health information that they felt could improve the quality of their lives.

B) Perceived Health Status and Everyday Health Problems

When informants were asked open-ended questions about the health status of the village women, many of them found it difficult to generalize about the health of women as a whole. One informant said "I don't know...you and I see the women ...they are walking about, but we don't know...they walk about, they do go to the garden". Another said, "I think there are some who are sick, but they don't say". Women did not seem to be accustomed to making generalizations of this nature, many of them finding it quite difficult to formulate an opinion. Also, it seemed that many women simply felt they did not have access to this sort of information about other women. Some said that women were reluctant to share personal health information with one another. As the above quote illustrates, some women felt they could only make inferences from what was outwardly observable (i.e. they could see that women were at least well enough to go work in the garden).

Of those informants who were able to respond to the question (see appendix 1, question B]2) many felt that the health of women was good at present, or at least unremarkable. When asked about the health state of the village women, they typically replied "they're good" or "they're strong". The following are some of the remarks that this group of women made:

My feeling is that they're quite all right...cause they do a lot of work.

I haven't heard that they're feeling tired, they feel quite all right, they're not sick...its like one's husband is the one to do it [who it depends on] - he makes it so that the woman isn't too tired and she won't be sick...like the man too, he helps.

Oh, it's [their health] the same everywhere.

I think they're quite all right, they catch some small small sicknesses only, its like that.

Although none of the women interviewed conveyed that they felt the health of women was very poor, there was another large group, roughly a third of those interviewed, who described the health of women as in the middle range, the response in *bislama* that best typifies this being *i gud lelebet* (which might be best translated "quite good but with room for improvement"). When asked to explain, some informants named sicknesses such as flues or malaria. A few others identified problems such as irregular periods and recovery after childbirth. But these responses were few in number, and didn't fall into any particular pattern. A common theme that did emerge though, from the remaining informants within this third category was that of women feeling tired, weary, or sore in relation to heavy work and in relation to the work associated with bearing and caring for children:

Its hard for mothers...to clean the house, look after all the children,...like at the house eh...like husbands too, they don't look after them [their wives] well, this makes it so that the women they feel that they're so weary...this place is no good, no good.

They're feeling tired,...like me, I want to go do something, but I feel I'm tired.

When there's too much work like this, like today, tomorrow, no rest like this, we just drag our bodies..and they don't have much power anymore.

Some they are slack [tired, weak]...some are just lazy...some can't work, they're tired because of all the children, they're having too many.

Some are sick...like their backs are sore, legs no good.

One woman, who was known to be skilled in traditional healing techniques and whose help many women sought, told me:

I'll tell you... some, like its their backs, some, their legs are sore...so that in this place, for plenty of women its their backs, legs too...I think because they work too much, they carry many heavy things.

In addition to being questioned about the health status of the village women in general, women were also asked how their individual health was, and then, using a conventional medical systems approach, about the various parts or systems of their body (see Appendix 1, question C]1). There were found to be only a few women with conditions they considered serious and who would consider themselves "sick". There was one woman, for example, who had diabetes and another with fairly severe abdominal pain who was later admitted to hospital with a possible diagnosis of cirrhosis of the liver. There were also two women who had recently (i.e. in the last two weeks) had malaria and felt they were still recovering. A high proportion of informants, however, reported that although their general health was quite good, they were troubled by certain bodily ailments which, although not considered to be sicknesses as such, were nevertheless troublesome. For example, many informants described their bodies as "strong" or "*i oraet nomo*" ("quite all right") but then added a qualification such as "except for my knee" or "but my back only." When informant responses were tabulated, it was found that on the day of the interview, 48% of women had muscle, joint, or back problems, and 44% suffered from skin conditions of some sort.

Skin conditions included itchy rashes, scabies, sores, boils and ringworm. Several of the women were plagued with widespread ringworm which seemed to be resistant to treatment; although they had tried various remedies, both western and *kastom*, it always returned. Scabies was a severe problem in some families, particularly those with small children. One woman had, in desperation, sprayed house, bedding, and clothing with household fly-killer having already tried, with little success, more conventional remedies.

Women related joint problems to undertaking heavy work, particularly to carrying heavy loads of produce back from the garden or working long days in the copra grove. One woman, for example, twisted her knee when carrying a heavy bag of copra. Another sprained her wrist while slashing grass. In a few cases, the injuries were quite incapacitating. One women in her early thirties, for example, injured her hip while carrying a heavy load of produce back from the garden and was unable to walk for two or three days. More often joint problems caused less incapacity but were chronic and intermittent, being aggravated by heavy work.

Although on the day of the interview only ten women reported that their backs were sore, for one third of those interviewed backache was said to be an intermittent problem

(women would commonly state "oh, plenty of times my back is sore"). Again women associated backache primarily with heavy work in the garden and with splitting and shelling out copra. Both back and joint problems were common in younger as well as older women, although they did seem to intensify with older age. It was interesting as well, that three of the women reported having very tender (probably bruised) sternums as a result of fastening their *kaliko* against their chests when carrying heavy loads of produce back from the garden.

Many of the women interviewed also reported that they commonly had headaches. On walking through the village, it was not uncommon to see them with *kaliko* wrapped around their heads so as to provide a measure of symptomatic relief. Headaches were said to occur most commonly as a result of working in the hot sun, or from missing or being late with meals (which often happened if the women were working in the garden). They were also associated with malaria.

Eye problems⁴, especially pterygiums, injected sclera (due to infection or allergic reaction) and refractive problems, were also common, as were dental problems (i.e. "toothache"). For most toothaches women took analgesic tablets (purchased at the local store) for pain relief and persevered, rather than going to the dentist at the nearby hospital (some confessed that they were afraid of the needle while others said that they were just too busy to go). A few of them did venture off to the dentist, but only when they reached a point of desperation. A few informants reported gynecological concerns such as pelvic pain, irregular periods, painful periods, or heavy bleeding associated with menopause. Likewise, there were a few scattered complaints with regard to chest, heart, stomach and urinary problems but these were generally uncommon.

Four of the women had sustained recent⁵ injuries as a result of violent assault which were, at the time of the interview, still causing them some incapacity. Two of the women had fractures of the forearm as a result of beatings from their husbands. Another two women had injuries as a result of assaults from other relatives. In one case, a woman had been involved in a dispute with her brother-in-law and had received a blow to the scapula with a piece of wood. At the time of the interview the shoulder was still tender and had limited mobility. A second woman had received a blow to her ear from her (male) cousin in a dispute over fishing.

C) Common Health Practices and Interventions

Not surprisingly, the people of Nasilar were found to have a well-developed (and constantly evolving) system of health beliefs and practices which resulted in a wide range of therapeutic options⁶. These ranged from simple home remedies, to the use of *kastom* leaves, to abdominal massage

techniques, to counter-sorcery techniques, to prayer, to western medicine, and, on the preventive side, to the observance of various taboos. Each of these will be briefly considered.

Women reported the use of steam treatments, hot compresses, binding their heads with *kalikos*, rubbing coconut oil into the skin, drinking lemon tea, the use of modern analgesics, sleep, and various other measures to treat or prevent minor illnesses in their families. These minor illnesses most commonly included coughs, colds, chills, headaches and fevers. Home remedies were usually used as a first line of intervention, before the help of other healers was sought or in cases where the medicine provided by the hospital or mobile health team was found to be ineffective:

When my boy, that is my grandson, he catches a cold, when the people from Rural come, they give cough medicine to him, ... I'm supposed to give it to him in the morning and at night. I give it but I look, the child's not all right. There is one way to do it, my thinking on this is sure. When I go off to the garden, I tell his mother, "You must bath the child, but not outside, in the house only...after he is bathed you rub the coconut oil that I made on every part of his body. After, you must put clothes on him, he must not go naked or he can catch a cold." [That night] I go, I boil some water, after I boil it, I let it cool a bit, I take a towel and put it in the hot water, ... after, I put it on his throat, his back, arm, leg....O.K. I look, now the child's cold is going away, tonight he will sleep well.

Kastom leaves, that is traditional medicines made from locally available plants, were also in common use. Some of these, such as those used to treat common illnesses like colds and fevers were known to many people, although there were a few women in the study who claimed to have no knowledge of *kastom* leaves at all. Of these, a few said they were afraid of them; the others claimed that they didn't have knowledge of them because they had no old folk in their extended family who were knowledgeable about them. Most of the women however, had knowledge of at least some *kastom* leaves. There were also some people in the village who were known to be experts in *kastom* leaf medicine; I was able to identify and speak with four, although there were quite possibly a few others. Many women in the study had sought out these experts from time to time. On other occasions, they had simply consulted with members of their own extended families who had greater knowledge of leaves than they themselves.

Leaves were sometimes boiled and the water drunk, sometimes squeezed into water, the water then being drunk, sometimes used topically, and sometimes heated and applied as compresses. Women claimed to have used *kastom* leaves for a wide range of conditions including cough, fever, malaria,

dengue, fish poisoning, back pain, joint pain, pelvic pain, ringworm, rashes, boils, eye infections, and anaemia. Women had also used leaves as contraceptives, as abortives, to augment labor, and to treat infertility. Some healers claimed to have leaves to treat illnesses such as tuberculosis, cancer, and diabetes, although none of the women interviewed were currently using these. One even claimed to have a treatment for AIDS.

Kastom leaves were equally important in treating *kastom* illnesses⁷, that is illnesses caused by supernatural forces such as devils in the bush, the spirits of trees, or sorcerers. In almost all of these cases, a leaf was the required treatment. Two of the women interviewed lamented regarding the deaths of their children; the cause in both cases had been *kastom* but they had realized it too late. They had taken the children for treatment at the hospital. Had their children instead been given leaf medicine immediately, they claimed, they would still be alive.

Although there were some individuals who believed strongly in the efficacy of leaf medicines, many, even though they used them, were skeptical and felt that although they were worth trying, they were often a bit of a "hit and miss" affair. Some would try a *kastom* leaf for fever, for example, with the expectation that they would go to the hospital if it proved ineffective. Several informants expressed reservations about leaf medicine, explaining that it could be helpful if one really had the expertise, but that, in many cases, healers just guessed and didn't really have a good understanding of what was going on inside the body. Surprisingly, one woman who was known to be an expert in *kastom* leaves commented "kastom medicine...its good, but the hospital - yes! [its really good, better]"

The commonest therapeutic intervention that informants reported using was that of abdominal massage, or what is known as *holem bel*. When informants were asked about the sorts of treatment modalities they had made use of in the past year, 25 had been to the hospital outpatient department (most commonly for treatment of malaria), 16 had used *kastom* leaves, but 33 had sought out someone to *holem bel*⁸. *Holem bel* refers to a technique of deep abdominal palpation, wherein internal organs, if found to be enlarged or out of position, are slowly maneuvered back into place. Most commonly the spleen is said to be enlarged, to have fallen down, or to be in the way of other organs and for this reason the technique is sometimes also referred to as *holem splin*. Sometimes it is said that the two spleens (usually meaning the spleen and the liver) have come too close together, sometimes that the trachea, liver, or spleen are blocking the esophagus, or, sometimes, that the heart has fallen down out of place. Apparently, these abnormalities can occur for many reasons but the usual explanation is that they have resulted from undertaking heavy work. One woman who regularly treated women using *holem bel* explained the etiology of the spleen falling down as follows: "[its from]

the type of work where you carry an axe to cut firewood or anything heavy, like if you lift up something, then the spleen is coming [down or out of position]". Some women claimed that these problems could also result from not eating on time, or that they came concomitantly with malaria. But even in the case of the latter, malaria was not seen to be the sole cause, and heavy work was usually implicated as well. This condition affected men, women, and children. When I asked how it was that children could be affected, one informant simply commented that they too sometimes carried heavy things, i.e. they sometimes lifted up other children.

Symptoms that were most commonly relieved by *holem bel* included sore abdomen, sore back, loss of appetite, a sensation of "tightness" in the abdomen, and "malaria" (which usually included the preceding symptoms plus some additional ones such as headache and fever). The following are some responses women gave when asked how they felt when their spleen fell down:

The spleen is too hard, I can't eat well and my body is very slack...

I feel that my stomach is sore from it, I feel too that my back is sore from it, and I just can't eat well either...when I eat, the food reaches my stomach, it just comes back out, I throw up....like my stomach is hot, oh its hot... after, my back is the same.

Although the symptoms just described are the ones *holem bel* was most commonly used to treat, the technique was, at times, also used to treat a wider range of disorders including pelvic pain, morning sickness, heart palpitations, heartburn, sore chest, convulsions, or general malaise. It was also sometimes used for diagnostic purposes. One woman explained that when she had had pelvic pain, she first went to a woman to *holem bel*. After examination the woman told her that her illness wasn't a serious one and that the doctor wouldn't have to operate on her. She was then happy to go off to the hospital to see the doctor for diagnosis and treatment. Some women who practiced *holem bel* were also skilled in midwifery techniques. Pregnant women often saw these healers so that they could check the position of the fetus and turn the fetus as necessary.

Individuals who were skilled in *holem bel* sometimes combined this practice with not only the administration of *kastom* leaves, but with other healing techniques as well. These included warm compresses applied to the whole body in order to make the person sweat (this helped "let out" the sickness), back massages, head massages, and massages to other sore or injured parts of the body. Sometimes pieces of broken glass were used to make small incisions in the skin. This technique was used, for example, on the back for relief of back pain.

There were many women (and some men) who were said to be skilled in *holem bel*. I spoke with five although there were undoubtedly several others. Women preferred to go to someone with this skill who was part of their own extended family but if necessary would venture to someone beyond. So popular was this form of therapy that one informant told me that a workshop had been organized three years earlier. A woman from a neighboring village had apparently come and given demonstrations and explanations to the women with regard to *holem bel*. In the case of most healers, however, the skill had been passed on to them through a family member, usually a parent or grandparent.

Some traditional healers used, along with the administration of *kastom* leaves and *holem bel*, another healing technique known as *singsing*. *Singsing* referred to a form of therapy in which the healer would sing to the body and/or illness of the affected individual or, more often, to a dead ancestor who was thought to be causing the illness. The healer would place her hand on the part of the body affected and then softly sing or chant. Sometimes the singing would simply involve telling the individual that they would be all right and affirming that the sickness would leave them. More often it involved singing to an ancestor suspected of causing the illness. If the healer was correct in her identification of the particular ancestor causing the illness, she would begin to make yawning motions with her mouth. The correct identification of the individual causing the illness would be enough to end the illness. One woman related her experience of this form of treatment as follows:

... that Saturday, back when I was pregnant and didn't feel good, I said to John, I told him, 'Let's go to Pemili... to see that woman.' We went and she sang [sing-sing] to me. After, I was tired and I slept. Then she held [*holem bel*] my belly, after she held it, she sang to it again. Then she told me, '*olfala* [old man] Bobby has done this to you.' And she asked me 'Have you been going outside alone at night?' I told her 'yes, I go outside alone at night, if I want to go outside I just go...to the toilet'. 'Yes' she said, 'this is what has caused it'.

Women who healed using this method (I was able to identify only three) explained that whereas in the past, many people had sought their help, more recently *singsing* had fallen into disrepute. This, they said, was mostly as a result of the church, more particularly the activities of an evangelist from a neighboring island who preached against this practice. Some informants, even other healers, spoke negatively of the technique, stating that they never used it. "She gives *kastom* leaves, but she prays" said one informant of a healer she sometimes saw, "she doesn't sing to Satan".

Finally, some women consulted with *kleva* with regard to their illnesses. Although the term *kleva* was sometimes used rather loosely by informants to refer to a range of traditional healers, it was generally recognized as the more specific term to refer to a healer with the power of clairvoyance, that is the ability to dream and thereby disclose the underlying reason for an illness and the appropriate cure. The *kleva* I interviewed functioned as a sort of medium, receiving her wisdom from spiritual beings who she communicated with during her sleep.

Kleva were not consulted on an everyday basis. In fact, only three of the women interviewed said they had consulted a *kleva* during the past year. Although there were said to be some individuals within the village who claimed to have this power, several informants told me that they were skeptical. "They just deceive us" said one woman, "because of the money". There were, however, two *kleva* who were relatively well respected: one, a woman who lived about fifteen minutes walk from the main village, and another, a man from the southern island of Tanna, who lived a longer distance away, about one hours drive by truck.

Kleva were usually consulted in cases of sudden severe illness or death, strange unusual illness, or illness that seemed to be resistant to all other forms of treatment. One woman, for example, had been troubled for months by a pulsating sensation behind the sternum. When the sensation was present she felt nauseated and couldn't eat anything. After seeing the doctors at the hospital and a local man for *holem bel*, she finally went to a *kleva*. The *kleva* "dreamed" for her, detected the source of her illness (sorcery performed by one man in the village), and prescribed the leaf medicine that finally cured it. When speaking about it with me, the woman reflected on the fact that the medicine of *waetman* (white people) was only effective for some kinds of illnesses: "if it is a straightforward sickness, yes" she said, "but if its something like an evil spirit ...[no]"

Prayer was another intervention that was common in all households; all the women interviewed indicated that they had at one time or another had someone come and pray with them with regard to an illness in the family, in many cases during the past year. It might be the pastor, some church elders, or just parents, aunts, and uncles of one's more immediate family. Sometimes it would simply be a woman's husband who would pray with her, although this was more often the case in those households where the husband was an elder in the church. The pastor had also recently announced in church that a prayer group had been formed and that anyone who was sick should call on them to pray for them. Women had had prayer for fever, cough, joint pains, abdominal pain, pelvic pain, diabetes, malaria, and many other illnesses. One woman reported that she had had very difficult labors until the elders had prayed for her; with the birth of her last three children, she had had no difficulties.

During the interviews, many of the women articulated the importance of their Christian faith and prayer in the context of health and illness. Many said that prayer was important in ensuring the efficacy of both *kastom* medicines and western medicine. Informants who were themselves healers usually mentioned that ultimately the power to heal came from God, no matter what the healing modality, and that prayer in conjunction with healing techniques was very important. One woman said that she never went to the hospital without praying first. This was essential in terms of determining what the outcome at the hospital would be:

I never go to the hospital without seeing the elder first - so that the power of God can work.... then I go to the hospital and the doctor gives me the *right* medicine and my sickness heals quickly...but if I don't seek God first, I know that I'll go to the doctor and he may tell me my sickness is a big one....cause the doctor is wise, but God gives the doctor his wisdom.

Women spoke less of interventions that were undertaken primarily to prevent illness than they did of those undertaken to cure. There were some women who did speak of the importance of avoiding chills and draughts, of eating well, of not over-working. With time, it became apparent as well though, that in a certain sense, there were many traditional preventive practices the women followed: although most informants could not give comprehensive accounts as to why they respected certain taboos, the common underlying fear they expressed was that failure to adhere would bring misfortune, often in the form of impaired health. In other words, the observance of traditional taboos was, in a certain sense, preventive practice.

Although some of the younger women were skeptical of the need to observe traditional taboos, there were few, if any, who were certain enough to completely disregard them. There were various food taboos, for example, that women followed when pregnant or lactating. A pregnant woman could not eat turtle or the baby wouldn't be able to walk well, she could not eat certain kinds of fish or the baby would have trouble breathing. Impurity taboos related to menstruation and post-partum were also quite strictly observed by the village women. Menstruating women were not allowed to cook or handle food to be received by men or men could become ill. Particularly if men had abdominal pain, carelessness in this regard was sometimes postulated as the cause. There were also taboos that governed the relationship between a woman (or a man) and her in-laws. A daughter-in-law, for example, should not address her mother or father-in-law by their name and she should avoid being in close physical proximity to them. She ought not to walk past them without cowering down, or even wash her clothes in the same basin as theirs. Again, failure to adhere could bring illness. One older woman told me how she had transgressed

this taboo once as she had wanted her daughter-in-law to massage her back for her. Her daughter-in-law agreed to do so, but not long after she started her eyes became grotesquely bloodshot and red. She emphasized, in summarizing the story, that here she had thought the taboo custom was nothing, but sickness had come suddenly because of her failure to observe it.

Finally, it was found that western medicine also had a well-established role in the prevention, diagnosis, and cure of illness (particularly the latter two). Women from Nasilar frequently commuted by bus to the hospital out-patient department in Norsup. They most commonly reported going to out-patients for the treatment of malaria⁹, but they also reported seeking treatment for cough, fever, toothache, skin infections, and injury or trauma. Often they came to hospital accompanying their children who were commonly sick with fever and/or cough.

Some women were so familiar with modern treatments for malaria, chest infections, or skin infections that they would access and administer the medications themselves. This might mean getting antibiotics from a friend who had some leftover, asking for medicine from the mobile MCH team, or purchasing simple medicines (such as analgesics) at one of the local stores. One woman, for example, who was eight months pregnant, had not yet been to ante-natal clinic (she was atypical). She had been too busy gardening to go. Instead she acquired iron tablets and nivaquine locally and put herself on the appropriate ante-natal regime.

Almost all of the women in the study went to hospital for ante-natal care and delivery. Although some of the older women (now past child-bearing age) had delivered some of their children at home, over the last five years I was able to identify only four women who had delivered a child outside of hospital or health center. Three of these said they had wanted to deliver in hospital but were obstructed by weather (i.e. heavy rain) and transport problems. The fourth had thought she should stay at home since her father-in-law had just died and custom dictated that the immediate family not leave the house for 30 days. She had delivered the baby at home, assisted by an older woman who had practiced as a traditional midwife in the past. In general, women spoke favorably of the services at Norsup and assumed that this was the appropriate channel for ante-natal care and delivery. None of the women in the study expressed concern about the quality of ante-natal or delivery care, although some women reported that transport to the hospital could be a worry (particularly in the evening or night when there were no buses running.)

In addition to the curative services provided by the hospital, the women also had intermittent contact with Rural Health, primarily through the MCH team which visited the village every one to two months. Although the broader responsibilities of the team include monitoring and promoting the health of mothers as well as children, the

nurses concentrated almost exclusively on the care of the "under-fives", i.e. weighing, immunizing, and treating illnesses in small children. Indeed the women themselves spoke of MCH activities primarily with reference to care of children. For some of them, the MCH clinics represented a chance to have children receive medical treatment without the work-time lost and costs incurred in travelling to the hospital. Some seemed to use the opportunity to restock on medicine for their family. In terms of health education, women reported that in the past they had been given health talks on such topics as the importance of good nutrition and family planning although during the nine months of the study, no health talks or educational health activities were observed (apart from the one-to-one counseling that nurses sometimes gave to mothers whose children were underweight or ill).

D) Perceived Health Priorities

Perceived health priorities were identified by evaluating and comparing information from three different sources of data: 1) unstructured interviews initially undertaken with key informants, 2) responses to open-ended questions asked during the formal interviews (Appendix 1, B)1-3) and 3) responses to the very structured question included in the formal interview (Appendix 1, D)1) wherein informants were asked to choose priority health problems from a suggested list or suggest one of their own. Both family planning and the need for a better water supply were priorities that were supported by all three sources of data. Infertility and domestic violence (more specifically wife-beating), although identified by a smaller number of informants in response to question D)1, were also considered priorities, as the issues emerged spontaneously in the unstructured interviews with key informants as well as in the formal interviews in response to open-ended questions¹⁰. They were also health concerns of a highly personalized and immediate nature (in the case of infertility, for example, some women sought out the researcher on their own initiative in order to discuss the problem and seek advice). The responses to question D)1 broadened the list of health priorities to include: controlling malaria, cleaning of the house and village, better cooking and nutrition, more education about sicknesses (i.e. T.B., AIDS), better housing, and building toilets. As a considerable number of women did choose building toilets and cleaning of house and village in response to question D)1, these will be briefly considered, along with the aforementioned priorities that were more clearly identified. The other responses, however, represented the thoughts of only one or two women and did not relate to the more common themes that evolved from the larger body of data. They will, therefore, be considered secondary and omitted from the discussion.

Improved Water Supply

Many of the women interviewed stated that the one thing they felt would improve their lives as women was an improved water supply. Several informants raised the issue spontaneously with the researcher, and in response to direct questioning (question D)1), over 25% of the women interviewed identified this as their first priority. Women emphasized that water is required for all of women's work. As one woman commented, "You and I need it for *every* thing". Water is required for washing clothes and dishes, for food preparation and cooking, for bathing children, and for most household tasks for which women are responsible. The following quotes were typical of women's felt need for an improved water supply:

I am thinking [in response to your question] that water only, ... we must have a lot more of it...because water now, you and I, all women, want to use water for cooking, washing the children's clothes, cleaning up the house, cleaning everything, ... its the side [realm] of women uh?

...water supply, that would be good...water, its like you and I have life in it.

Although men sometimes helped out women by carrying water, it was generally considered the purview of women, as it was essential to all domestic tasks for which they were responsible and, on a practical level, men were often absent when these everyday domestic tasks were being undertaken. Furthermore, when informants were asked who carried water the most (women, their husbands, or other family members) the answer was almost always that it was women themselves. "Me now, I am the one who carries more", informants typically responded.

At present, there are a total of eight wells in "greater" Nasilar (the area included in the jurisdiction of the chief) but as for the main village area, where the majority of the households are located, there are two. Both are shallow, bore-hole wells with cement casings. There are no handpumps; the wells are open at the top and plastic buckets or tins are lowered down into the water to be filled and then carried back to households suspended on long pieces of bamboo. Apparently one of the wells is contaminated with salt-water and the water is used only for washing (never for drinking). The other one is also said to be contaminated with salt water but to a lesser degree; some people drink it and some don't. If rainwater is available, this is preferred over well-water for drinking. A few houses with iron roofing have rain-water storage tanks, others have simpler innovations such as eavestroughs collecting water off a few iron sheets into a barrel. If it is dry season and rain water is scarce, some use well-water for drinking (some

drinking it directly, others boiling it first), others drink juice from green coconuts.

It is doubtful that the well-water would be very pure, even were it not contaminated with salt water: everyday buckets and tins that have been sitting on the ground are lowered into the well (hence contaminating the well-water with dirt and sand from on top) and children periodically throw rubbish down into the boreholes. The women said that the wells have to be cleaned about three times a year in order to take out the debris.

Some of the settlements that are not in the main village area also have their own wells; some of these are boreholes, like those just described, but some are traditional hand-dug wells. In the case of the latter, the wells are very shallow and relatively broad, the dirt having been dug out by hand. There are no casings or covers; one has to go down onto the dirt and mud to collect the water in a bucket. Some women said that they thought the water from these traditional wells was often cleaner than that from the bore-holes and that they preferred it for this reason. But if they lived back in the main village area, it was too long a distance to carry it.

There were about 10 women in the study who lived in settlements away from the main village area which had no wells at all. Most of these women had to walk 10 or 15 minutes to the nearest well to get water, or, in a few cases, to a creek. For women who lived in the main village area (the majority), water was relatively accessible, the two bore-hole wells being no more than five minutes walk from any household. But even so, by the time the buckets were filled in the hot sun and carried back to the house, in most cases about four times a day, it became quite a tiring and time-consuming prospect.

It is significant that the women in this study seldom conveyed a sense of concern about the quality of the water in relation to illness. Apart from one informant who did tell me that if she drank water from one of the bore-hole wells it made her vomit, very few commented on the importance of a safe water supply for better health. Furthermore, in one settlement, where a traditional hand-dug well was located very close to some of the houses, the women there told me that they were not concerned about water, as for them the well was just nearby. (This is interesting as by public health standards, the water from this well would undoubtedly be considered unsafe). It was the work involved in carrying water, more than anything else, that motivated Nasilar women to identify an improved water supply as a health priority:

I think water only..., if it (the situation) could change - because you and I go to the well all the time to get water, we go, we go, until we're tired...it makes life too hard. Like the life of us here in the village, that's it now, its the work of the bush, like the

coconuts and all the work that we must do, life has been like this for a long time now... until we too are becoming old.

I think water supply only [needs to change] - because its very hard work.

The water supply situation had not always been like this; in the late 1980s the government set up a water supply system in this and several other villages in the area. The system included a deep well with an engine and pump, a large water storage tank and a series of pipes through which the water ran by gravity to various outlets throughout the village. A village committee composed of about eight members, two of whom were women, was set up. One young man, the son of the landowner on whose ground the pump was located, was sent away to a two week mechanical course and was responsible for the upkeep and repair of the system. A monthly fee of 100 vatu (about one Canadian dollar) was charged of every household to provide the income necessary for the purchase of the petrol for the pump and the general upkeep and repair of the system. The system functioned for only about a year: there were several breakdowns of the pump, which despite his mechanical training, the young man was unable to fix. A mechanic from the local government was called in a few times to fix the pump, but the pump continued to have frequent breakdowns and the villagers were told that they themselves would have to find and fund an outside mechanic. This never happened, partly because by this time the villagers were convinced that there was something inherently wrong with the system (which there was; the pump had been pumping up sand which kept damaging it), but also because there were not adequate funds in the "kitty" to hire outside help.

When women were asked about the failure of the system, they emphasized not so much the faulty mechanics, as the fact that collecting the 100 vatu per month was a difficult task and that there were many defaulters in terms of payment. On a few occasions, the committee had shut-down the water supply system completely because too many households were failing to pay. One informant told me, "a few only, they paid it" and said that had people paid, there probably would have been enough vatu to call in a mechanic to repair the pump the last time it had broken down. Regardless then, of the mechanical problems inherent to the particular water system that had been installed, payment, and therefore upkeep, had been an ongoing problem.

When inquiries were made as to why many households didn't make their monthly payments, it was clear that although there were *possibly* a few households that might not have had the vatu to pay, this would not hold true for the majority, since all would have access to some cash income and 100 vatu was not considered an expensive monthly fee (equivalent to a bus ride to Norsup or two or three shells

of kava). The issue was obviously one of priority or perhaps principle. For some, informants explained, there was resentment about having to pay for something as basic as water, the implication being that it should be provided it free. One informant told me:

If they are paying for that [water supply] then their money goes there, cause it needs money too [to run]...but if we carry the water from the well, its good, because we don't have to pay...but this [water system], if its in use, we have to pay for water again and again...they [some villagers] talk crossly because of this.

Discussions with other informants however, brought to light another dimension of the problem; they felt that many times men didn't recognize or value the work that women did. If they did, they said, there might be less dispute about paying for the water. As it was, paying for water wasn't a high priority. Vatu was diverted to other "priorities", for example, to paying for kava. Here are one woman's comments on the water supply problem:

I don't know what their thinking is [those who don't pay]...but it was one very good thing to help all women, to give them water...it's like they don't think seriously about the hard work of women, some men they recognize the hard work of women, some men they don't recognize it...this is it now, I'll tell you that when they have watu, they want to spend it on kava only, but they don't recognize the hard work of women...if a woman holds the watu, if you come and ask her to pay for water supply, she will pay, and some men too, who understand, they'll give it, but those now, who don't understand, they won't pay the watu... but if in this place, if they were paying the watu, the water supply would run all the time... when it was no good [in disrepair], they'd have the watu to pay a man to come and fix it...but that's it now, the situation remains like this.

Family Planning

Family planning, more specifically the ability to limit or space pregnancies, was an issue that was of paramount concern for many women. Not only was it identified by many informants as an important issue in response to direct questioning techniques (just over one fifth of informants identifying this as a health priority in response to question D1), but it was the health concern that informants themselves raised the most frequently in the context of unstructured interviews and open-ended questions about how women's lives might be improved. Furthermore, women did not discuss the issue in an abstract theoretical

way as some did when discussing, for example, sanitation; the issue was, rather, a highly personalized one. For example, one woman, just after I had explained the purpose of the study and obtained her consent, asked, in an almost interruptive manner, "Like myself, I want to ask about family planning, how is it? How does a woman use it?" She went on to explain that she had a daughter who was one year old and was now six months pregnant with her third child. Another woman, when asked a very general question at the beginning of the interview regarding the health concerns of women blurted out "I want to use tablets or something...I'm easy [have few reservations] about this, but my husband is strong, he wants children again and again but I'm already tired". This woman was eight months pregnant, this being her 9th pregnancy. These examples are not atypical; many women expressed a strong desire to space or limit pregnancies. They were, however, for a number of reasons, also quite skeptical about modern family planning methods, and only a very small number were currently using any. Women commonly told me "like I want to, but I'm afraid."

Motivating Factors Accounting for Women's Interest in Family Planning

Analysis of interview transcriptions revealed a number of motivating factors which accounted for women's interest in family planning. For some, economic considerations were paramount since raising a large family was, in modern times, becoming an expensive proposition. Furthermore, few families had a regular income, apart from copra and market earnings which were perceived as unreliable given market fluctuations and cyclones. When asked what was most important in improving the lives of women, one informant replied:

I think this is it now, the side of family planning - I think this is it - because if you and I have got plenty of children, then there's not enough vatu to pay for school fees, clothes, food and housing...if you work for a big company, they can pay you, you can get a good salary, but if not...

Another informant commented, "because lots of children means vatu...and like the price of copra, it's no good".

One informant commented that she couldn't understand why it was that white men, who to her thinking always had plenty of money, had just small families, and black men, who were poor, continued to have large ones. She emphasized that it now takes considerable vatu to look after children well, but that, despite this, many women continue to have six, seven, or eight children.

A few of the younger women, particularly, felt that family planning was important in order to space children, so that there would only be one baby in the family until the first one could walk. They felt that a rest in between was

important for the mother so that she could cope with the work that was already involved in mothering a child and managing all her other domestic responsibilities. In a similar vein, there were a few women who stated that you needed to look after the children that you already had well, and that closely spaced pregnancies might interfere with this.

Some women were motivated towards family planning by a desire to avoid pregnancy in unstable relationships. There were three women in the study who had small children but were neither married or cohabiting. One of these, a woman in her early thirties who had two children, expressed concern about the unavailability of family planning methods to single women. She explained that sometimes a girl will make friends with a boy and then he will "*lego long hem*" (leave her). This had happened in her case, as a previous boyfriend, by whom she'd had one of her children, had moved elsewhere to work, leaving her alone. In her situation, she reflected, she would have been better off using "family planning"¹¹. She was doubtful however, about the possibility of obtaining contraceptives from the midwives at the district hospital, even now. Family planning, she felt, was reserved for married women who had two or three children already and the consent of their husbands.

This informant's perception, based on hearsay and on her own observations, was, in fact, quite accurate. Midwives are wary of distributing contraceptives to unmarried women because of the community criticism that will fall upon them, particularly in rural settings where there continues to be considerable debate (albeit quiet debate) around the use and availability of family planning methods. Religious leaders, as well as government and community leaders, emphasize the importance of promoting stable traditional family relations and curbing promiscuity, and many of them view family planning as a threat to these. So although family planning is available, it is most readily available to married women who have at least two or three children and the consent of their husbands. Beyond this (and in the absence of a national policy¹²), much is left to the discretion of the midwives who must deal with the pressure of the community at large.

For the majority of the women interviewed, the biggest motivating factor for family planning had to do with the workload, that is the time and energy that bearing and caring for a large number of children involved. One woman, when asked generally about the life of women replied:

...it all right, but this is the thing - you and I have such hard work with all the children, one or two only are good but plenty like this, its *hard* work, it makes it so that all the mothers, they can't work very well...two or three children only are good but plenty make hard work for everyone.

Other women made similar statements:

... because when we have full-up children, this is hard work...its hard to look after them all - as for myself, if I feel that I'm pregnant, I feel cross, cause I must carry it and its heavy, on and on...I am cross at this man [her husband]... I am cross at him because he now, he is the one making children.

I think there's enough now [children in my family] cause we look after the children, on and on...you and I are tired already.

Some women emphasized that because of the heavy responsibilities associated with child-care, they were not free to *wokbaot*¹³ and visit with their friends, to join in women's activities (i.e. P.W.M.U. or women's club) or other community activities:

I think its good that we talk about family planning...you could help a lot of women in this area - too many children means the women, they're not interested in doing things to improve life here.

Similarly, some linked having many children with having to work harder in the garden:

I think it would be good if they had less children and took family planning, cause when there's too many children, they can't join together and work, they think about all their children, they think too much about the gardening.

As mentioned earlier, most women felt they did more domestic work than their husbands, that is child-care, cooking, home-care, and gardening. Often discussions with regard to family planning arose within this larger context, that is within conversations regarding the roles and responsibilities of women. Often the descriptions informants offered of home-life were characterized by a deep dissatisfaction, sometimes resentment, and even cynicism with regard to this perceived imbalance, with the women carrying a much heavier work burden. One woman described her interest in family planning in this way:

...like myself, I'm interested in family planning because I look at my home, my home-life, ...its too hard, because my husband doesn't help me much, he doesn't think very much about us [here at the house]...if he gets some money, he just spends it on nothing [useless things], like kava or cigarettes...he doesn't think about us.

She later continued:

Its good if we have three or four children, like that... because I feel this [life as it stands] is too hard...I look...all the men, they feel good, but me, I don't feel good because there's too much hard work here at home - and they [the men] just walk around like that...they walk around, they come and see that we are working hard at the house but they're not sorry for us, sorriness they haven't got.

Another woman commented cynically, "To make children, that's the work of the man...you look, he will make children until he has full-up, ...then he spoils his woman [with hard work]". Several other women expressed similar feelings, which although cannot be said to be representative of *all* village women, do underline a strong sentiment that many women hold:

...but there are some [men], once they've given their wives children - its done... now the mother *she* works,... he just walks around ...this makes the mother tired - she looks after all the children, goes to the garden, comes back, cooks...

The style of a man is like this...he makes his woman pregnant, she has the baby, she works hard...then he walks around, on and on, he drinks kava, spends money on kava, goes to the nightclub.

Having discussed, at some length, the issues and factors that motivated women to limit family size, consideration must also be given to the impetus some women felt to have more children. Although several informants claimed that they thought a family of three or four was a good size, it was clear that more important than the *number* of children, was having *both* boys and girls, preferably a balance of each. A few informants emphasized that it was important for children to have a sibling of the same sex. More often though, it was the differing roles and relationships to parents that the women emphasized: one informant explained that girls were good because they could help you with your work (i.e. cooking, child-care) and boys were good because they would be with you when you were older (the area is patrilocal). Likewise another woman, who had three girls, the youngest of which was five, explained to me why she was pregnant with her fourth. "When you are old" she said, "the girls will go away to live with their husbands, but boys will stay near you". Another informant curtly stated "a girl is just like a bird [will fly away]".

Family Planning and Decision-Making:
The Issue of Control

Regardless of women's own sentiments about family size and family planning, it was clear that they had only limited power and control when it came to making decisions on such matters. I once asked, in a group setting, who it was that wanted large families: mama, papa, grandparent, or who? The reply was that it was not so much a matter of conscious decision-making, as that men often demanded intercourse, with little thought (or responsibility) taken for the consequences (that is pregnancy). "Its good that we talk about this" said one woman, "because us mothers, we don't need more children...the men are responsible - they're no good [laughter], they are always wanting something [intercourse] all the time". This informant went on to explain that unlike women, who were usually acutely aware of the risk of pregnancy, men often insisted on intercourse, with little thought of the consequences. Furthermore, women were not uncommonly threatened with violence if they did not concede: "if you... if you don't let them have your body, then you'll get a beating".

For many couples, family planning was a contentious issue. One informant explained it this way:

Some men, they are glad [for family planning] ...but sometimes, the woman (only) wants to take family planning...they fight, fight, fight, fight...on the side of the women, plenty of them want family planning and they would use it...but this is the problem now.

In some cases, informants simply said that their husbands wanted more children while they didn't. One woman commented, "He wants children, on and on, but I am tired already". When asked why she thought he wanted lots of children she replied "because he thinks there's no shortage of land". This line of reasoning is not uncommonly heard from Ni-Vanuatuan men who oppose family planning. It obviously reflects an association between family planning and population policies, and a minimal awareness of the role of family planning for women's and children's health.

In many cases though, it was not that men were altogether against limiting family size¹⁴. Some were unsure about what methods of family planning they considered safe or acceptable, and some men apparently felt uncomfortable accompanying their wives to the hospital which they perceived as an unfamiliar and even threatening environment¹⁵. In some cases, men seemed to be very distrusting of modern methods; afraid particularly of invasive procedures associated with doctors and hospitals. One informant, who was very anxious to have a tubal ligation, told me about how her husband had agreed to the procedure and her name had already been put on the list. Shortly before the day of the surgery however, they had

heard that an Aunt of hers had died of appendicitis. This aunt had, several years earlier, had a tubal ligation and this informant's husband was sure that the more recent illness was related. As a result, he changed his mind about his wife's surgery. This informant described how angry she felt, and lamented that if only the surgery had been scheduled before the death of her Aunt, she would have been able to have it done.

Whatever the case, it was clear that women did not have the authority to take family planning without their husbands' consent. The woman mentioned above concluded her story saying, "I don't know now [what will happen]... cause the man is the boss....but he doesn't know what you and I [we women] feel. I keep telling him but...". She wasn't hopeful. Another informant, who had recently given birth to her eighth child in hospital, described how the nurses had tried to talk to her husband about the possibility of a tubal ligation but he had refused: "All the nurses - they tried to tell him but they couldn't do a thing....because the man, he's the boss" she concluded despondently. In some cases, the issue had become the focus of a power struggle, men simply refusing to relinquish control over their wives, regardless of the particular benefits that others (i.e. health professionals) might have felt family planning could bring to them and their families.

During the interviews, several women mentioned that it would be better for men and women to be interviewed together and also for health education talks about family planning to be directed to both¹⁶. They were, of course, acutely aware that family planning education directed solely to women would have very limited effects:

The thinking of the women is this: there must be men *and* women together, not women only, its better men with women - because the women know that if the men won't agree, they can't use it [family planning] that's it.

Current Contraceptive Use

It was found that of all 69 village women interviewed, 6 had had tubal ligations and 1 currently used a condom with her husband. There were no others who reported current use of a modern family planning method¹⁷. Nine couples used the "calendar method" (some version of calculating "safe days" on the basis of the last menstrual period), although only 4 of these were found to be using the method correctly. There were also a few couples who had agreed to use abstinence as a temporary measure (i.e. to abstain from intercourse for a year following the birth of their last child) and a few who claimed to control their fertility simply by having intercourse very infrequently. Nine women used *kastom* leaves as contraceptives.

As noted earlier, many women expressed fear and suspicion with regard to modern methods of family planning¹⁸. Women had serious misgivings, for example, about using oral contraceptives because they knew they had to be taken every day and felt that there were too many variables in their everyday lives that might interfere with this¹⁹. Furthermore, there were some widespread rumors about the effects of failing to follow the tablet regime exactly; if, for example, you were taking tablets and missed a day, you would definitely get pregnant (your chances were higher than were you not on the pill) and any child so conceived (while his mother was taking oral contraceptives) was likely to be born with birth defects. IUDs and condoms were, for a variety of reasons, similarly distrusted and although it was common knowledge that some of the women had had tubal ligations, most women expressed fear with regard to the latter, particularly with regard to being "cut" (having surgery).

Contraceptive leaves were considered a viable option by many women, although most didn't know how to identify or prepare the leaves themselves. There was said to be one woman in Nasilar who knew. A few women had obtained the leaf from her, others had gotten it from relatives or friends on other parts of the island. According to some informants, the *kastom* leaf had to be taken only once in order to be effective; according to others, it had to be taken twice with a six week interval between doses. Some informants claimed that it always caused permanent sterility, while there were others who said that another leaf could be used to reverse its effects. Few women were completely confident in the efficacy of the leaf; some stated that they were afraid to try it lest it be ineffective or lest it make them sick. Those women who had used it said that they found it to be effective and spoke positively of their experience with it, although one of the younger ones was concerned about whether or not she would be able to conceive again.

In cases of unwanted pregnancies, leaves were sometimes used as abortants. Only a few women told me they had used these (there may have been many more). Again, knowledge of how to obtain these leaves was not widely distributed, nor was there confidence in their efficacy even for those who had used them. One woman in her mid-thirties, who was a mother of eight, called in her youngest child and showed me some deformities on his leg and foot. She told me of how she had wanted to have a tubal ligation but her husband had refused. When she had become pregnant with this child, her seventh, she had, in desperation, tried an abortant leaf at one month. It had failed to abort the fetus but these deformities, she believed, were the result. It was a painful story for her to relate. Another older woman related how she had used a leaf abortant several years ago. It too had been unsuccessful in aborting the fetus but had made her so ill that she had been hospitalized for several

weeks. She later gave birth to an apparently healthy girl. But when the girl grew up, she died in child birth; the mother was sure that the abortant leaf was in some way implicated.

As already mentioned, a small but considerable number of couples used natural methods of birth control. Nine couples used some sort of "calendar method" wherein they calculated "safe days" for intercourse on the basis of the last menstrual period. Those couples who had used the calendar method successfully for a number of years were very satisfied with it and felt it to be the method of choice. These were mostly older couples (i.e. in their late thirties or their forties) who had misgivings about modern contraceptives and somehow (through reading a book in one case, through the midwives at the hospital in another) learned about this natural method. There were also women in the study who were attempting to follow the calendar method but were doing so incorrectly, not abstaining from intercourse on the right days of the cycle or not for long enough periods. Even though some were pregnant as a result, they were, surprisingly, not disheartened with the method itself, but anxious to be corrected and discover where they had gone wrong. For these women, and for a surprising number of informants, natural family planning was considered the method of choice, despite warnings that the method had a fairly high failure rate and despite the admission of some women that they might well have difficulties getting their husbands to comply. Women felt that it offered the advantage of being within their control (in so far as they were not reliant on doctors, midwives or hospitals for supplies or check-ups), of being natural ("I don't have to take medicine" they would comment), and in cases where husbands were motivated to limit family size but were reluctant to accompany their wives to the hospital or clinic, it was "portable" and immediately accessible. Even women who were doubtful about their husbands desire or ability to comply with the method badly wanted information about it. Given the reluctance of their husbands to consider modern family planning methods (and their own reservations about the latter), natural family planning seemed the only alternative; for them, it was this method or nothing, and they felt it was worth a try.

Infertility

Although the women in this study who identified infertility as a health priority were few in number (there were only five women who reported having difficulties conceiving²⁰), these women were highly concerned and motivated with regard to seeking help. On some occasions, hearing a nurse was present in the village, they sought me out, asking me to come and talk with them in the hope that I might be able to offer them some advice. One woman had a child previously but was unable to conceive in a subsequent

relationship, another had used a *kastom* leaf contraceptive a few years ago, was now having irregular periods, and was unable to conceive a second child. Another had been married for three years but had not yet conceived.

Although infertility is a highly sensitive and personal issue in any cultural context, in this setting, where alternate roles for women (other than that of mother) are few, and where women have traditionally been valued and exchanged to a large extent because of their ability to reproduce (Lini 1982), it definitely constitutes a crisis. Although these particular women seemed as much motivated by their own internal desire for offspring as by external pressures, they did tell me that if one was married for two or three years and a child was not forthcoming, one's husband's family would be grumbling. One informant also mentioned that failure to get pregnant was sometimes an underlying reason for beatings. "Sometimes, if a woman hasn't had children," she said "her husband can beat her because of this."

Domestic Violence

Defining the Problem

Wife-beating was an issue that key informants raised early on in the study and one that was of paramount concern for some women. Although most informants didn't identify it as their top health priority, considering, for example, water supply or family planning as more important, for those that did, the issue was considered a very serious and personal one. Furthermore, when informants were asked directly (Appendix 1, F)1) whether they thought wife-beating was a significant problem in the lives of women, all but 10 of the 69 women interviewed stated that they thought that it was. The following are some of the comments women made in response to that question:

...no, this is a *big* problem....as for me, in my situation, its number one. My husband is just like this - we are fighting, fighting...always he is hitting me. (This woman then related that five years ago she had been hospitalized with severe bruising and swelling of all her limbs when her husband had beaten her with a piece of wood. Then last year she had had her forearm broken in the same way).

Oh, in this place, they can beat the women, kick them just like a football...this habit is rubbish, but there's lots of it that goes on here.

...a *big big* one- this is one big trouble for women!

...some, they beat their wives, they swear at them, they spoil them ...they [the women] run to the bush, or to the shore, to the sea at night, sometimes they go to the bush. They come, they carry their children and come and hide with us...plenty of them do this - so that life is no good, oh its no good. You [men] want a women to come and help you, help you in the house, to cook, wash, sweep - then we look, you beat her like this.... plenty of this goes on.

For those few women who said that they felt wife beating wasn't a major problem, some felt it was something that happened only occasionally when men were drunk, others acknowledged that it was common but seemed to feel it was merely a normal result of couples fighting and the issue didn't cause them a great deal of concern or worry. But the vast majority of the women felt that it was a significant problem, the above quotes being quite typical.

Of all of the women with whom the issue of domestic violence was discussed (64 out of the 69 women interviewed²¹), only 11 (17%) had *never* been beaten by their husbands and 20 (close to one third)²² stated that they had been beaten (physically assaulted in some manner²³) during the past year. During the course of the study, three women in the village required medical attention as the result of severe beatings; one had scalp lacerations and both bones of the forearm fractured, a second also sustained a fractured forearm, and a third, scalp lacerations. There were also less serious assaults that manifest themselves as swollen eyelids or bruises, for example. One young women reported that she had been beaten with a strap for objecting to her young husband's extra-marital affairs. "Like my body was black..." she said. After we had discussed the issue for some time she lowered her voice and looked directly at me asking, "Can you help me? If you've got any advice, can you tell me?"

Of course, all women were not equally open in terms of discussing the problem and there was a spectrum from those who considered the problem to be nonexistent, to those who considered the problem to be acute and brought up the issue spontaneously with the researcher. One woman flatly denied that wife beating occurred at all. "Oh in this place" she said "I don't think men hit their wives very much...they're good to them...I think in another village - but in this place, all the women feel all right, like the men don't beat them, they don't spoil them". This comment was atypical. It did, however, highlight the vulnerability that some women felt and the need that some had to protect the reputation of their families and their village.

Although the majority of informants felt that wife-beating was a serious problem, their conception of what, exactly, constituted the problem was not straight forward: almost all informants felt that husbands had the right to hit their wives under certain circumstances. There were only

7 of the 64 women interviewed on the topic (11%) who felt that a husband was never justified in hitting his wife. If a woman didn't listen to what her husband told her to do or if she failed to perform her domestic duties such as cooking, keeping house, and taking care of the children, he had the right to physically discipline her in order to teach her. Most women were supportive of this form of "teaching" and a few even encouraged it. Informants explained its role as follows:

Yes, suppose he [her husband] comes and the food isn't ready, everything is lying all about...yes [then] he has the right... because its up to me only, I am the one looking after all these things ...he does this to teach me so I learn something.

A man can't hit a women for nothing, Mrs....if a woman does something that's wrong, yes, her husband can hit her...its good if he hits her, then he corrects her because sometimes the women are making the men frustrated. If he hits her in this way, then its good. But if he hits her so as to kill her [i.e. dead], this is no good...But if he hits her to teach her, its good.

Some women - they just want to walk around, they don't want to wash for their husbands, they don't cook for them...the man then he comes and sees and is cross with his wife - he hits her- because the thinking of men is like this: "we paid for you because of all this work here, and you, you aren't doing anything"...this is it now. It makes a man cross and he hits his wife.

...like for us in *kastom*, we think that the woman, she is to look after the house. The man, it's for him to carry all heavy things, its for him to make the house, to work copra, to do this kind of thing. But the woman, its for her to clean the house, cook, wash the plates, wash clothes, weave, look after the children, this is for the woman - her now. We think that the woman, she is for the house only eh?...she shouldn't be visiting all around, she must look after the house first. When you marry a boy,...like if it were me and I were walking around like this, my husband would hit me to tell me, "woman, yours is the work at the house".

For most women, these convictions, regarding the right of a husband to physically discipline his wife, seemed to be rooted in their understanding of *kastom* and, for some, reinforced in their interpretation of the church's teaching. Most women felt that their husbands had the right to physically punish them because they had paid brideprice for them and, in a certain sense, owned them. Wives were therefore obligated to perform their domestic duties and if they neglected these, their husbands were justified in

physically disciplining them. Some women also expressed the idea that the right of men to physically discipline their wives was based on the biblical teaching that the husband was the "head" of his wife, and that the role of the husband, as leader and protector, could involve physical discipline. "Yes, he has the right", commented one woman, "because you know, when you're married in the church, the husband is the head of the woman". Another woman commented, "he's the boss - he protects the family in the house". Several informants emphasized the man's moral authority to dictate and discipline, given his role as head of the home:

...because, the woman, *she* comes to live with the man, so if he tells her something she should do, she *must* do it. If he tells her a duty and she doesn't do it - like some, then they hit their wives, some, they just scold them.

Despite the fact that some beatings were thought to be justified, all women had serious objections to the many that were perceived as unjustified or out of proportion to the offense. As one woman stated, "the man has the right to hit his wife if she does something wrong, but if she does things right, he has no right *at all* to hit her". One informant explained to me that there were two kinds of *kilim woman*²⁴. On the one hand, she explained, there were the kind that were administered in order to teach a woman if she failed to perform her domestic duties. The second (improper) kind, which were becoming increasingly common, occurred when a woman was not neglecting her domestic work, yet was beaten for *samting nating* (something insignificant), or simply because her husband was drunk:

O.K. there are two kinds of beatings - if we do our work in the house well, the men can't hit us...and this is good we can just lead a happy life. Sometimes though, the man is just wrong, he is beating his wife [even though] his wife has been listening to what he says...so, you see, she can still lose.

Some women were best able to give examples, such as the following, in order to explain the types of beatings they considered improper:

This is a big problem, cause when they drink, they come and hit the women like this - but its not the right way because the woman is sleeping inside with all the children...its not right. He is cross because of some small [insignificant] thing...he doesn't talk to her first, he just hits her suddenly - I look, its not right - he should come and talk calmly to her first.

Why It's a Problem: Effects
and Implications

When women talked about why they felt beatings were a problem, several themes emerged. For some, it was simply the brutality of the beatings; that is the direct physical and psychological trauma inflicted on the women involved. This was often expressed using the term *spolem*²⁵. One woman, for example, said, "You look at some women, their husbands are beating them so that they're spoiling them...they hit them, they make their blood run". Another woman commented, "Its no good, cause it spoils women...they hit their arm - it's broke, or they make them shake [with terror]". Another stated, "If men hit us women, then we're weak from it, we're sick from it".

Some of the women emphasized the effects of wife-beating on their role as child-care providers, saying that if women were beaten frequently, and feeling unwell as a result, that it was hard to look after the children well. One informant, an older woman, went so far as to state the following:

You look...they've lost lots of their children, lots of them, because they [the men] are scolding the women, they are spoiling the women. The women, then they can't look after the children well...when the children are sick, they can't look after them well...this is it now, its why lots of children have died.

Other women made the following comments:

This is a big problem here...like they beat us, then we don't feel good, yet we are the ones to take care of their children...its not right.

Hit them [the women] a little, scold them...all right. But the men [who really beat their wives] are crazy... who's going to look after the children?

Some women worried about the possibility of men "overdoing" it, and beating their wives to the point of death, leaving the children without a mother. "If he makes a mistake" said one informant, "then the woman is dead...so then what about all his children? "

Some women focused on the psychological effects of wife-beating on children. They stressed that it upset the children and set a bad example for them:

What can his [her husband's] thinking be ? ...all the children are there, if he wants to hit me, he just hits me, and the children are just there, like that. Their thinking won't be straight...if they look, mama is crying, papa beats her - its not the right way - if there are no children, you can hit the woman, it's good,

but when the children grow up, its not straight at all.

If the children are big and he does this, they feel no good.

Many women stated that beatings had decreased over the years of their married life; they had been more severe and more frequent when they were first married and had lessened or stopped altogether after having several children. Some thought their husbands had just matured and settled down, but many thought it was because of the children; that once children were old enough to understand and watch, that this was a serious deterrent for fathers. Some women also stated that when their sons had gotten old enough, they had come to their defense and that the beatings had stopped for this reason.

Some women said that beatings were unwarranted and unfair since women, in their estimation, did more work than men. At the least, it showed that the contributions of women were taken for granted and not valued:

Men are beating women without reason... cause women do hard work with the children, more than the men...[the man] he walks around, he comes to the house, he looks, all the food is there [ready] in the house...its hard work too to look after all the children. If the children are sick, it's the woman only, she takes them, she takes them to the hospital. Her husband he shouldn't beat her ... [but] when the men, they get alcohol like this, they come and beat the women again, they spoil them, so that there's bloodshed.

One informant, one of the few who said that beating ones wife was never justified, explained her rationale as follows:

We women, we're not like men, we're different...men are strong, we women, we're not...we women, we look after the family...the men, they come, they beat us...then they walk around, walk around - but they don't know what we do at the house: we look after the family, we make all the food, we look after the house...the men, they come and hit us, they drink...now they run away, they walk around, they visit everywhere. But at the house, its we women now...some men they don't understand about this. We're trying to make it so that we're equal with them, but the men, they make it so that they're higher than us women...many, many of them think this way.

Finally, a few women emphasized that wife-beating was unfair because women were not really strong enough to physically retaliate and, in this sense, men were always at an advantage. Indeed, I heard of some cases of domestic violence where women were the aggressors, and many others

where women retaliated physically when their husband's assaulted them. There were also said to be cases where women physically fought one another. So it was not as if women saw no place for physical aggression. Yet, in the majority of cases, informants claimed, men were the aggressors and women felt they were in a disadvantaged position in terms of their physical strength.

Causes and Precipitating Factors

There were many causes of domestic disputes and beatings that women cited: failure of women to cook on time, complete housework, or take adequate care of children; failure to consent to intercourse; conflict over whether or not to have more children (women often not wanting more); disputes over money management (i.e. whether the woman has handed over all the money she has earned at the market or whether the man is spending too much money on kava); conflict over kava drinking in general. As mentioned earlier, some women felt that beatings were intensified in cases where women were thought to be infertile. Some women also speculated that, in some cases, beatings were relatively severe because "he paid too much for her". In other words, if a woman had meant considerable cost for a man and his family (i.e. her family had charged a relatively expensive brideprice), he was more likely to treat her harshly, particularly if he found fault with her.

Informants also stated that one of the main reasons for marital conflict and violence was jealousy. As one woman said, "for all of us women now ...when a husband is jealous, he will hit his wife...this is a big reason why men hit their wives." Both women and men were said to be easily provoked to jealousy, in some cases, even by seeing their spouse conversing with another man or woman. The jealousy that men expressed towards women though, was not only in relation to other men; sometimes it was in relation to the time and energy of women. If women were thought to be taking too much time away from their domestic responsibilities to be involved in women's activities, for example, or if they spent too much time visiting with other women, their husbands might feel jealous. One woman reflected:

They [the men] just don't want it - for women to go out like this... plenty [of women] don't come out and join women's groups like PWMU or women's club... they're thinking about this, this jealousy here.

When women described, in more detail, the sorts of marital conflicts that resulted in violence, certain commonalities were detectable. Underlying the more superficial issues that provoked violence seemed to be a more basic inability to tolerate disagreement and to resolve conflicts in a peaceful way. In many cases, men expected to

be heard and obeyed and if they felt their authority to be undermined, they resorted to violence. Some informants simply said that if they were told to do something by their husbands and they didn't do it, i.e. their husband's authority was challenged, they were hit. Others were able to articulate the sort of power struggle that ensued between themselves and their husbands:

One shouldn't try and go over the other, one shouldn't be over another. If I hear that my husband is talking crossly to me too much, I let go... so that my anger cools down, so that he can talk on and on, ...[then] he won't hit me. But if the two of us try and go on top, then he is really cross and must fight me right away.

The root of it [violence], is...in the house, woman and man...if the plan of the two is the same, fighting you haven't got, peace is in the house - but if the talk of the two of you is like a scale, where one goes up, the other goes down, that's it..."

Refuge or Recourse for Battered Women

Most women felt that there was little they could do if their husbands were beating them in an unacceptable manner. One older informant, when asked what sort of action women could take to curb wife-beating, commented cynically, "They're close to dead, yet they still stay with their husbands." I was told that traditionally women in intolerable situations had some recourse through their own family, and through the chief of the village. A woman could ask her father or brothers to speak with her husband, or, if this was ineffective, the case could be taken to the chief and the man made to pay a fine. Informants, however, said they knew of very few cases, if any, that had been brought before the chief in the last ten years. The chief himself said that he had been involved in sorting out some cases of wife-beating but had found the giving of fines to be counterproductive and therefore tended to take a more conciliatory role wherein he tried to help mend and reconcile the marriages. He seldom gave fines, he explained, because, in his experience, women who pressed charges typically withdrew them not long thereafter. He said that he wasn't sure why women did this; perhaps they felt sorry for their husbands or, more likely, he thought, they were afraid. Although a battered woman might, in her anger, make a complaint to the chief, when she went back to her house, her husband would somehow pressure her to withdraw it.

Informants who discussed the issue with me were certainly not at ease with the option of going to the chief. One young woman simply shrugged and said "I feel like it's just too hard". Another commented that if her husband were to find out she had gone to the chief, the beatings might

well intensify. One woman explained that if women went to the chief, their husbands would often come behind to present their versions and the cases would go no further: "their husbands just go and talk to the chief after them - in this way they block this place [this course of action]". And even if the chief were to intervene, some women claimed, these days men didn't always listen to him. "The chief hasn't got the power to do anything anymore" commented one informant.

In modern times, it has become possible for a woman to go directly to the police with a complaint of domestic violence. Sometimes she first obtains a medical report from the doctor which she then takes to the police. A complaint is filed and eventually the case comes before the magistrate. Again, however, informants told me that they didn't know of any village women who had followed through with this course of action. And again, some women said they were afraid that if their husbands were to find out they had been to the police, they would receive an even more severe beating. One woman who discussed the issue at length with me concluded:

This thing here [wife beating] we know its really hard work, we want to beat it - we work and we work but no...my thinking is that these women should just go directly to the police...but they don't...there's no way... they're afraid - I think they're really afraid of their husbands.

Some younger women said that when they were beaten they thought about running away, back to their parents (and sometimes actually did). Apparently, in the past, women sometimes did this, as a sort of "hideout" until their husbands' wrath subsided. This was seen as only a temporary measure though, and women emphasized that it was no solution to the problem. The women almost always returned to their husbands, often because they were worried about their children, sometimes because they didn't really want to leave their husbands, or, more often, because there were no alternatives. "We can't hold her" one mother commented, explaining that they could give their daughter temporary refuge but didn't have a right to keep her. Also, I was told that in more recent times it had become harder for women to take refuge with their parents, even for a short time. Their husbands would come looking for them almost immediately and demand that they return to them. According to some older informants, this behavior differed from that of the past when boys were not as "strongheaded" or determined, and more respecting of their in-laws. "But now, all men, all boys, they're different..." explained one older woman, "they act like strong men uh?...they make their wife to go and hide with her parents, then go and pull her back...they talk crossly to her parents and take her back saying 'why did you come to this place?'".

Despite any short term solutions, informants emphasized that once married, a woman was the property of her husband and had to return to him:

If he's already paid for her, if he hits her, she can't go back to her father... because he's paid for her already - he's got a right to her now. Or if they're married in the church, its the same...the father can't say anything, because he [her husband] has paid for her.

One informant, after discussing all of the possible courses of action that a woman might take, sadly concluded:

Its just like this: they block the place...like they make it so that they're [the women] afraid to go here, they're afraid to go there...so they [the women] just leave things as they are - the woman now, she takes the whip [beatings] and she just stays with her husband, she can't go any place...life like this is hard.

When women were asked how they thought the problem of wife-beating might be prevented or alleviated, there were a variety of responses. Some woman emphasized the importance of prayer, some spoke of restricting the use of alcohol, and a few spoke of physical aggression on their part in order to deter their husbands. Women also commonly talked about the importance of improving their own behavior (i.e. being more compliant). One woman, for example, said, "I think that he tells me something and I don't listen [then] he's cross...its up to me only - if I can change". Another concluded "If she can change a little bit, if a woman can listen to what her husband says, then things will be straight". Another woman confessed, "Its me, I talk too much, I'm the one who starts all the fights". On one level, these women were simply acknowledging that they sometimes initiated marital disputes by provoking their husbands anger (the obvious solution then, being to avoid the latter). But what their comments also reveal is the role that self-blame plays in their understanding of domestic violence and the extent to which wife-beating is a very effective tool for reinforcing, for women, the importance of adhering to socially prescribed roles and mores.

Finally, domestic violence is an issue that has also to be described within the larger context of kinship relations that figure so prominently in the organization of social life in Vanuatu. In so far as women are exchanged between clans, and expensive brideprices are paid in marital transactions, they play an important role in formation of alliances between groups, in exchange relations, and in the ongoing balancing of clan relations. Because of this, marital breakup is very difficult; often many members of the clan into which a woman has married will have been involved in securing the brideprice and many members of her parents families will have been recipients of a share of the bride

price. Sometimes the price set will be based on the price of a previous exchange in the opposite direction (i.e. wherein the wife's clan paid for a woman from the husbands.) When a woman is beaten and recourses of action are considered, the issue must be considered (on however unconscious a level) in a much larger context than that of the nuclear family. As noted earlier, sometimes there is a sentiment that too much was paid for the woman, and that her husband is therefore more entitled to discipline her if he finds fault with her. In effect, an incident of battery becomes meaningful and may even find some justification in the larger context of clan relations and interchanges. At the same time, when a beating occurs, it is considered very much a private as opposed to public concern. Women, reflecting on cases of wife-beating (other than their own) would typically comment, "I don't know what the problem is with those two". By making domestic violence a private matter, it can be quietly dismissed without disrupting the more extensive clan relationships that serious marital discord might threaten. A woman who reacts strongly against the conditions of her marriage has to be willing to endure all of the discord that reverberates throughout the larger social network.

Toilets

When women were asked directly what they felt was important in terms of improving their health, a considerable number did respond "toilets". At the time of the study, only about one quarter of dwellings in Nasilar had toilets²⁶, people using the beach or the bush, the traditional alternatives. Many of the women I spoke with however, were familiar with and quite enthused about water-seal toilets, which had been introduced as part of a large-scale environmental health project²⁷. Some of the women had seen the water-seal units in some neighboring villages and had been very impressed by them. Several even specified that these were the types of toilets that they wanted.

When women were asked how they thought having toilets would improve their health, they had difficulty responding apart from a few who gave the following explanations:

I think its good if one family has one toilet - like that is good...cause I look, all the flies come and sit down on the food...this makes us catch sicknesses.

Toilets- its good if we use them- waterseal. If we use the bush, the flies come and feed, they come back and sit down on our food and we get sick from this.

Although for some informants, toilets may well have been a felt need, there are some factors that make one question the sort of priority this health intervention really held in these women's lives. No informants initiated

conversation about toilets spontaneously or identified sanitation as a key issue when asked broader questions about improving their health and the quality of their lives. Women only mentioned the issue in the context of very direct questioning (Appendix 1, D)1). Furthermore, although some women were able to give a rationale for their choice, such as those shown above connecting poor sanitation with flies and communicable diseases, their explanations tended to be rather "academic" and depersonalized, rather than based on personal experience or immediate concern.

Some informants were critical of others who cited "toilets" as a health priority and of their of stated concern regarding poor sanitation, flies, and illness. One informant commented that women failed to make the more basic efforts inside their own homes to decrease the presence of flies, i.e. they didn't clean up, they left articles lying all about, they didn't use foods safes, and so forth. She concluded skeptically, "they only want toilets because they are free" (referring to the water-seal scheme). Furthermore, some secondary informants suggested that having water-seal toilets had become, in many districts, as much a status symbol as a health intervention.

When I questioned women as to why most people hadn't built toilets of any kind, they either said that they were unsure, that people didn't really think they needed them, or that people were too lazy to make them. "You look, they don't make any toilets" one informant commented, "the fathers are there but they don't make them". Another flatly stated "they're too lazy to make them". To construct a toilet (a basic pit latrine), she explained, was not a difficult matter; one had only to provide the food, and ask some male folk of ones extended family to come and dig the hole. The walls and roof could be made of locally available material and the project could be easily completed within a few days. The chief of the village complained to me that he had recently constructed a pit latrine and many of the other villagers were using it. Once it was in place, they liked to use it, he explained, but it wasn't a priority for them to build their own, despite the fact that there was no shortage of materials or land on which to do so.

Cleaning the House and Village

Finally, another small but considerable number of informants stated, in response to question D)1, that cleaning one's house and village was what was most important for improving health. Although these women represented a small number when compared, for example, with those who identified water supply or family planning as a priority, it was a common enough response and represents a common enough theme throughout the study that it warrants some examination.

Amongst those women who cited cleaning of the house and village as a priority, there were those whose responses were tentative. These informants seemed to feel that "cleaning up" was the most appropriate answer, and sometimes sought verification from the researcher in this regard. One woman, for example, in response to question D)1, said: "we clean up the village no?... this is so sicknesses don't come. Is this what you're asking?"

In fact, for many informants the term "*helt*"²⁸ itself was strongly associated with "clean-up" (this being an initial methodological difficulty that the researcher had to overcome²⁹). When, for example, women were asked directly what they thought the meaning of *helt* to be, some of them responded as follows:

[it means]...clean the house, plates, spoons, clean yourself...

helt means...it helps you and I so that we clean the house well, look after the children well, make them bath...take out all of the dirty things [out of the house], throw them away or beat them clean....this way is good...we won't catch sicknesses.

It's to help all women, to teach them so they can work, so they can clean the house.

...[it means] we clean the village so that our village is clean.

If women then, had learned to associate *helt* itself with "clean-up", it is not too surprising that some would assume "clean-up" to be the correct or most acceptable answer when questioned about health priorities. At the same time, there were also some informants who were more aware of and able to articulate the connection between illness, particularly vector-borne illnesses, and poor hygiene. They were able to explain that, in this regard, "cleanup" was the first line of defense against illness:

I think [the most important thing] is to clean your body, clean the house, after outside- to pickup all the rubbish, all the [coconut] shells...[or] the mosquitoes will come [and live] inside them....go sack them, and put everything outside so that you can beat it and clean it ...then we won't catch sicknesses and get weak for doing our work... we must clean everything here, then we'll be strong enough to work in the garden...we must do it like this, [because] if everything close to us is dirty, we'll catch sicknesses and we'll be too weak to work, to do anything.

Women who identified "clean-up" as a priority tended to emphasize that although they themselves recognized the

latter as important, women generally did not make the effort they could in this regard. They explained that sometimes water supply was prohibitive or more often, that women didn't make cleaning up a priority, given their overriding interest in gardening. Some women were quite critical of others in this regard. As mentioned in the preceding section, there were those who criticized others for claiming they needed toilets when they made so little effort to clean up in and around their homes. One woman, however, explained with more compassion, that with gardening as a high priority, there was just not enough energy left for household (and village) cleaning:

In this place, this is it now... you are thinking about the garden only, it keeps you right up until dark...you come [to the house], you're weak, you can't even do anything, everything dirty is lying all about. You're so tired, you just go and lie down on your bed...everything just stays where it is...[yet] it's our work as women, everything in the house.

Finally, for some women, cleaning, and good housekeeping in general, were related to health less because of their effects on microorganisms and communicable disease, than because they were socially sanctioned signs of a good wife and mother and were thereby linked to overall happiness and harmony in the marital context. Many informants related that maintaining a clean and tidy home was the appropriate purview of the mother and that if women failed to do this their husbands became cross. Cleaning up, therefore, could be linked to health in the broadest sense of the word, i.e. harmony in the social context of one's life. A woman who kept her house and surroundings clean and well-organized won the favor of her husband. He would be pleased with her, not cross with her, and not obstructive with regard to her own plans. One informant explained it this way:

I think that the number one thing is this: to be cleaning your house... cause I see that its the life of us women, we do everything - we clean up, we do everything that has to be done in the house....whenever your husband tells you to do something, and you do it, he sees, and he sees that its good - oh its good, oh its good... then you don't hear him talking crossly to you....also then your husband will like you and he won't do anything against you. Whatever you ask of him, he'll be glad [to give it]. "Yes", he'll say, "[because] you've done everything".

E) Perceived Etiology of Health Problems

Analysis of interview transcriptions revealed that informants identified quite a wide range of causes, or at least factors, that were either responsible for or significantly contributed to health problems. These causes/factors can be grouped into three broad categories: (i) immediate or "natural" causes of ill health with which little mystique was associated, (ii) supernatural causes of impaired health, referring mostly to *kastom* but also encompassing factors of a religious nature, and (iii) more broadly based factors of a primarily social and economic nature.

Immediate or Natural Causes

With regard to the first category, most common illnesses such as malaria, diarrhea, skin infections, fevers, headaches and so forth were accorded natural causes so long as they followed their natural or expected course. Malaria, for example, was associated with mosquitoes, and diarrhea was thought to occur because *samting doti i stap long bel* (something dirty is in the stomach). Coughs and colds were due to chill, exposure to draughts, and cold air. Women often commented, for example, that they ought not to work out in the garden for long periods in the rain, or they would become sick. As noted earlier, women associated joint pain and muscle strains with undertaking heavy work and headaches were commonly said to be the result of working long hours in the sun.

Weather patterns were also associated with some illnesses. Some women, for example, thought that sore abdomens, as well as diarrhea, were related to hot weather. "You get diarrhea, and your spleen falls down" commented one informant, "because its really hot". The time following a cyclone was also recognized as one in which illnesses (particularly fevers, headaches, malaria, and diarrhea) increased. (Indeed, if one considers the problems of dirty water, mosquito breeding, and food shortage that usually follow cyclones, this is most certainly the case.)

Diet and food hygiene were also recognized by women as important factors with regard to illness. Women implicated various foods as the causes of conditions such as skin rash, headache or abdominal pain and, as noted earlier, there were many taboos pertaining to pregnancy and lactation which implicated certain foods as causing illness in mothers or their infants³⁰. With regard to food hygiene, women said that food contaminated by flies could cause illness and some felt that mothers were not careful enough with regard to their handling and covering of food.

Although women were able to identify natural causes of ill health such as these, they often found it difficult to specify the mechanisms by which they caused illness. They

didn't consider themselves experts with regard to the latter and were not very interested in giving me explanations. "Those people from the hospital, they know", one informant told me.

Supernatural Causes and Factors

Within the category of supernatural causes of ill-health, the most common cause that informants identified was what was referred to as *kastom*. As noted earlier, *kastom* referred to causes postulated on the basis of the indigenous belief system, causes involving supernatural beings or forces. When informants were asked if less serious illnesses such as cough, fever, or diarrhea were caused by *kastom* the response was almost always a quick and emphatic "no". *Kastom* was most typically suspected in cases of very severe illness or in cases that were atypical and did not respond to western medicine. "When you're sick, oh you're very, very, sick" explained one informant, "you go to the hospital, they can't cure you, you come back now, they put it to *kastom*".

It was not, however, as if *kastom* was implicated as the cause of an illness on only the rare occasion. I was told that many cases of illness were attributed to *kastom* and during the course of the study, I heard of a wide range of conditions for which *kastom* was the postulated cause. These included sprained joints that were very slow to heal, prolonged laryngitis, chest-pain, infertility, and still-birth. Some informants said that they thought *kastom* was an overly-used diagnostic category. "They put plenty of sicknesses to *kastom*" said one informant, "but I don't think they're telling the truth".

A *kastom* cause of ill health most commonly meant sorcery, although it could also mean an illness resulting from the infringement of a taboo, or from encountering a devil in the bush. Sorcery was referred to as *nakamaes* in bislama, which meant the supernatural power possessed by some individuals to inflict misfortune, often in the form of illness or death, on others. To do this, the sorcerer sometimes invoked the power of a spirit medium (i.e. a dead ancestor) or, in some cases, the power was thought to rest with the sorcerer himself. "Yu yu stap karem nakamaes?" ("do you carry the power of *nakamaes*?"), an individual might be asked.

The belief system underlying most sorcery techniques seemed to involve a perceived continuity between individuals and anything that had been or would be in contact with them; the air in which they moved, the food they ate, even parts of individuals' physical bodies which had been removed such as pieces of hair or nail clippings (for this reason villagers were often careful to put away left over food especially if eating away from home, and to throw hair cuttings into the sea as opposed to leaving them scattered about). To inflict illness, then, one could retrieve a piece of hair or clothing from an individual and perform sorcery on it. Or one could put a magic potion into an adversary's

food or into a cigarette which would be smoked in the same room as her. Less directly, one could leave something along a pathway where that person would walk or even spit something into the wind so that the wind would carry it towards them. These sorts of techniques were not limited to inflicting illness but could be used for other purposes as well, such as to attract the opposite sex.

It should be mentioned that sorcery was sometimes referred to as *posenem* (poisoning), although the term *posenem* usually carried a more specific meaning, that of an adversary putting a poisonous substance in one's food or drink (rendered poisonous purely on the basis of its pharmacological properties, or on the basis of the power imparted to it by a sorcerer). Poisonings were said to be quite common and there were at least two suspected cases in the vicinity of the village during the time the study was undertaken. The most common symptoms of poisoning were said to be severe abdominal pain and/or vomiting of blood. Although those with these symptoms were usually brought to hospital, leaf medicine was thought to be the appropriate cure. Although, in some cases, no supernatural means might be employed in order to poison an enemy (the avenger relying solely on the pharmacological properties of the potion), the help of a *kleva* would often be sought following a suspected incident in order to help identify the guilty party, to discern his motivation for the poisoning, and to reveal the appropriate cure (i.e. the particular leaf needed).

In cases of illness caused by sorcery, the more fundamental cause was always social conflict, more specifically the ill-will of an adversary. One *kleva*, when asked what it was that caused most of the cases of *kastom* illness that she saw, simply replied "When one person is cross with another person - that's it now". Two examples encountered during the course of this study are illustrative. In the first case, a woman who was unable to conceive a child came with her husband to seek the help of the *kleva*. In the usual manner, she asked the *kleva* to dream: "You try and sleep and see the two of us...its *kastom* that's blocking us". When dreaming, it was revealed to the *kleva* that an old boyfriend who had been jealous of the woman had put a potion in her food so that she would become infertile. The *kleva* was shown the appropriate leaf to give her as a remedy. The *kleva* herself didn't have the particular leaf required but sent the couple to another man, about one hour's drive away, who was able to give it to them. Shortly thereafter the woman became pregnant.

A second example is of a woman who gave birth to a baby with a serious congenital abnormality, the baby dying shortly thereafter. There were many speculations as to the cause of this, all of them relating to *kastom*. One woman's speculation was as follows:

I think that the family of the husband doesn't want her [the woman] ...or maybe its that the family of her

husband didn't pay for her so that the family of the woman is trying to get rid of him slowly. This is how it happens in *kastom*. Its like this.

Although in most cases of *kastom* illness, the appropriate cure for the illness itself is said to be the administration of a leaf, retribution is seen as equally important, that is the identification and punishment of the party responsible. In a case where a dead man has caused the illness, the individual must be identified and sung to, this seems to be enough. But in the case of a living man (and this is often the case), a beating is not uncommonly considered the appropriate punishment. I naively asked one *kleva* what would be done if the man causing the illness was a live man. "Oh, if he's alive," she retorted, "they'll go beat him!...they're going to go fight!" In some cases, the traditional island court may be invoked to look at the evidence and decide if a suspected person is guilty. If the case goes through the traditional court system, the usual punishment is the payment of a heavy fine, often a number of pigs to be given to injured party or, if deceased, to his family.

Some informants felt that foreigners were immune to *kastom* illnesses; that these were conditions that could affect native people only. One day, for example, I told one informant that I often cooked for my husband during my *sik mun* (monthly period) and that he had never become ill as a result. This did not surprise her at all. She explained that somehow the bodies of black people and white people are not the same in this regard, that they are fundamentally different, that their blood is different. She said that she wouldn't expect my husband to get sick and that I shouldn't doubt the taboo for this reason. She told me that she herself had seen definite cases where men had developed headaches or abdominal pain because their wives failed to adequately observe *sik mun* taboos.

With regard to supernatural factors in illness causation, it was also found that the Christian religion played a significant role in providing a context for the understanding and interpretation of the presence of health problems. Although its role in this regard was more subtle than that of *kastom*, it did become apparent from time to time. For some women, for example, the presence and persistence of health problems implied that one's Christian faith wasn't strong enough. One woman, for example, who was desperate to conceive a child, had sought help from both western and traditional practitioners. More recently, a travelling evangelist had prayed with her and her husband assuring them that they would have a child. Unsuccessful thus far, her conclusion was that the problem rested with her husband. "He's not really a man of the church", she said, "I think his faith is not strong enough". Similarly, another woman, who was experiencing intermittent pelvic pain, explained to me that the severity of her condition and

the distress she experienced was proportional to her Christian faith; when her faith was strong, her demeanor and her condition improved, when it was weak she deteriorated.

One informant stressed that the generally "wanting" state of women, including their more narrowly-defined health problems, were the direct result of their spiritual state:

I've done a lot of observing... I've been thinking and telling my husband...I tell him, "You look at the life of the women, why is it that their life is like this? its because they make God wait". One thing that's very important in your life - you must put God first in your life... before you go do all these other things.

This woman explained that women failed to adequately commit themselves, their lives, to God, that their values were fast becoming selfish and worldly. If they would first improve their religious and spiritual state, other aspects of their life would also improve.

Social and Economic Factors

Women were very aware, simply on the basis of their everyday experience, that their quality of life, including their health status, was rooted in relationships of interdependence, both within the nuclear (and extended) family, and within the larger social nexus. They were aware, for example, that their well-being was dependent, to a large degree, on the attitude and behavior of their husbands and that, in turn, the well-being of their children depended on them. They were also aware of political and economic factors that determined the availability of resources necessary to sustain health. And they pointed out the important role of the health services, such as the hospital and the MCH clinics, in health maintenance.

Discussions on the topic of nutrition were indicative of the role these women saw economic factors as playing in health matters. There were varying opinions, for example, as to why women and their families failed to eat from the three food groups³¹ on a daily basis, despite the fact that they were familiar with the nutrition guidelines set out by the Health Department, and their importance, particularly with regard to the well-being of children. Several informants stressed that women simply fed their children (and themselves ate) what was most convenient (rather than what was most nutritious) because of workload and time constraints. But others emphasized that there was still another very real problem with having a variety of foods available on a regular basis. If one considered, for example, what was available cumulatively throughout the whole year, a wide variety of fruits and vegetables might be identified. But at any one point in time, there might only be two or three of these, some of which might have been spoiled by insects or snails, and particularly this year,

much of which had been destroyed by the cyclone. The root of the problem, they explained, had to do with the economic conditions of their lives; if the price of copra was good, or if they were lucky enough to have husbands or family members with paid employment, they could supplement their usual diet with food from the store or market. Otherwise, it was difficult. One woman explained it this way:

Vegetables and meat too, we haven't got...right now the snails are spoiling all the island cabbage...if a father has a job with white men, then he'll have vatu and he can buy some different kinds of food... but because on our island, the fathers don't have work and now the price of copra has gone down, its no good- ...we can't find plenty of food, we can give them [the children] taro only, manioc, yam, banana, papaea, sometimes grapefruit,, ...if its the season, we can give them oranges...meat too, we can't be giving fresh beef all the time cause we haven't got any...if you've got money, you can buy it.

Some women commented on the role of economic factors and housing. One woman, when discussing the health of her family, commented:

For those of us who stay in the bush, the house isn't clean at all...if a man has vatu, he can make the house completely good ... us who are poor, we can't do the same. We look, the houses are all dirty...because life is too expensive.

Although bamboo, sago palm, and most materials needed for housing cost no money, significant improvements to housing (i.e. to make them completely mosquito, rat, and rain-proof) did entail some expense. Certainly having a cement floor to improve cleanliness was an expensive proposition. Given all of their other priorities, especially for families with large numbers of children, these sorts of home improvements were considered unfeasible.

Whether the discussion involved nutrition, housing, water supply, or transport, it was not uncommon for women to conclude "because there's not enough vatu" or sometimes "because the government's no good". Although there was some understanding of the national context of health and the effect of the local economy on health matters, knowledge and understanding of broader, i.e. global, factors that might determine the national economy was minimal. Informants sometimes commented that if only the party in power was replaced, the price of copra would go back up and life would improve. Expectations were very high during the months preceding and following national elections.

Informants also identified the government health service as essential to maintaining good health status. As noted earlier, informants indicated that while the level of

interest within the community with regard to preventive health interventions was not high, the presence of western curative medicine was highly valued and the services well-utilized. Many women (as will be described in the following section on "Change") viewed the presence of the hospital and the availability of western medicine as the most important means to improving community health. The mobile MCH team was valued in the same way with regard to the health of children. As one older woman in the village commented, "There's not a lot of sickness now [because] those from Rural, they look after the children really well".

Finally, analysis of interview data revealed that the attitude and behavior of women's husbands was a major factor that women identified as affecting their health. Some informants stated, for example, that if men helped with the heavy aspects of gardening and cash cropping that they didn't get overly tired and sick:

...like if its time to plant yam, to dig the holes, the husband does it. This way the woman isn't too tired, she won't get sick...cause the men too, they help their wives.

If I go to the bush with my husband, he does all the heavy work - I go to cut the grass only...that way I'm not tired, I'm not sick either.

The women, they feel all right,...like their husband's are good to them,...when we go to the market in Norsup, our husbands really help us - they help us load all the food in the truck and then drive it to the market.

Many women, however, expressed the converse side, that they were tired and weary primarily because they received little help from their husbands when it came to gardening and domestic work:

...but for the women in this place...it's hard, it's hard for them to clean the house, look after the children - all the housework...their husbands too, they don't look after them well, so that the women - they feel very weary...in this place, it's no good, it's no good.

I don't know how it is on some other islands in Vanuatu - if the men work a lot in the gardens- but I think on Malekula, I think its the women now who work and do all the heavy things... all this heavy work, it makes our bodies...like they start to become weak, we don't ever have our bodies fresh...when there's too much work, today, tomorrow, no rest, like that, we just drag our bodies and they don't have plenty of power anymore.

Discussions on the topics of family planning, water supply, and especially domestic violence made it similarly apparent that the disposition of a woman's husband was a very important health variable. In the case of family planning, for example, "*Sapos man blong yu emi gud...*" ("if your husband is good...") was a frequent qualifier that appeared in interview transcriptions; whether you could initially discuss with your husband the need for family spacing, whether you could obtain his consent in order to access modern methods, and whether you could use family planning methods successfully depended, to a large extent, on the willingness of your husband.

F) Change

Responsibility and Change

Informant's perceptions regarding change, more specifically regarding the means by which improvements to their health might come about, were very difficult to elicit. Women did not seem to be accustomed to thinking about such matters and questions posed by the researcher were often met with silence. Furthermore, from the data that was collected, it seemed that most women didn't feel that the responsibility to initiate change rested with them, or that they had the power or resources required to implement health-related changes in their lives.

All of the women interviewed were asked who they felt was ultimately responsible for improving their health (Appendix 1, D)4). Only 9 out of the 62 women who were able to respond to the question stated that they felt women themselves were responsible. All other informants identified external agencies as the more important actors in this regard.

A large portion of the women interviewed said that they felt it was the hospital and the Rural Health team who were ultimately responsible for improving their health. As one informant simply stated, "They are the ones who do everything that has to do with health, so that health can be improved". When asked to explain, many of these women simply stressed the curative role of the hospital; that when they were sick or had health problems, the doctors, the nurses, and the medicines were there to help them. To their way of thinking, the maintenance and improvement of curative services would ensure the health of women. A few informants suggested that the hospital was important because it allowed women access to modern family planning, which they felt was a major factor in improving their health. Others emphasized that the hospital, and more particularly the Rural Health staff, had an important role in instructing and directing them as to what aspects of their health *should* be improved and by what methods. What needed to happen, they would explain, was for Rural Health to come to their village and

tell them to clean-up, get immunized, or whatever they viewed as necessary:

When they come [Rural Health] and give us advice, then we can recognize what it is they are talking about.

I think it's up to the doctors and to Rural...they should come and talk about something that we need to improve...if its just all us women, we won't do it right. They should come and help us, this is better.

I think what they need is for the men and women of Rural, or someone like that, to come and help, to tell us what they can do to improve life here... they know... they can come and tell us 'you do this, do this, like this..'

Some women even emphasized that a major barrier to improved health was the failure of women to adequately listen to those in the health service and do as they were advised by them:

I think that in this place, it's the attitude of the women. If the attitude were good, then when you folks [from Rural Health] came and talked with us, then we'd do what you told us, to do with health.

When you come to share ideas, to encourage the women, they don't take it up...all women nowadays they're not like women used to be, before. The women now, they're not good. I think it's because of too much knowledge, too much education.

A similar response, that is of women feeling that the health department ought to initiate and instruct with regard to health matters, was evident when women were asked what they thought they would like to be given health information about. To this some women simply responded, "you, you can give the ideas to us" or "just tell us something that's good for us".

While many women, then, felt that the responsibility to improve health rested with the hospital or the Rural Health team, there was another large group who thought that it was the chief of the village who was ultimately responsible. These informants felt that the chief could motivate women, ensure that women joined together and participated in health-related activities, that he could advise them with regard to specific problems, and that he could correct them as necessary. The following quotes are illustrative:

I think its the chief only, because this is how we live in the village, the chief only is the one - he can tell us what we should do.

The chief is the one who makes things go ahead...he looks after the people in the village.

The chief of the village - he can make the health of women improve... all the women, they listen to what the chief says...like if there's something wrong with the women, the women are all fighting with each other, the chief can straighten them out.

If we want life to improve, to get better for us...[then] if the chief talks to you and I and asks us to do something, we can help him and do it, if the elders tell us to do something, we must do it. Then our village will improve. Its not good if we just sit idly and don't listen to what the chief and the leaders say - if they tell us something, and we don't do it, its no good.

For another portion of the women, the responsibility was said to rest with the government. Some simply said that because the government had money (relative to them), it was responsible to provide basic health improvements such as improved water supply and toilets. One woman commented, "The government can carry out everything, but all of us at home... we can't do anything". And another said, "...we're here...but its really the government only, its the government only that looks after our country". The implication of these statements seemed to be that whereas villagers had little power or resources through which to bring about desired health changes, the government did, and was therefore ultimately responsible. Some women felt that the government was the best alternative in modern times given that the chief was perceived as inactive, ineffective, and/or losing his traditional authority. One woman said despondently:

When it comes to the chief doing anything, he's asleep...it's the government only that can do something - like make toilets, water supply... yet we live like this [nothing has changed].

Another woman commented:

We've seen that lots of times the women have been asking something of the chiefs in the village, but it looks to me like they can't make the life of women improve. So now I think it should go to the government...the government now, it can make the life of women improve.

There were a small number of women in the study who stated that they felt the responsibility for change rested with women themselves (9 as opposed to the 53 who chose external agencies). Some of them were younger, relatively well-educated (i.e. they had some secondary schooling³²),

and quite articulate in expressing this sentiment. In contrast to the other women, some of these informants felt it was inappropriate, even demeaning, to be told what to do. They emphasized that they had their own minds and it was therefore up to them to take responsibility:

I think its up to the women only...like if you say its up to Rural or up to the chief ... the chief - he can't come and tell you that you have to clean up your house, he can't come and criticize you...like you've got a mind too. You live in the house with your husband, the two of you must have ideas and its you who must do this or that.

Like if I know something about health, I can do it to help and improve the life of my family - its up to me only, my knowledge, my thinking, like that...its not up to my husband, its up to me, the woman, to improve health.

The overall pattern that emerged from the data, however, was that the majority of women felt that the impetus and the formula for change ought to come from without, from external agencies, particularly from those individuals or groups in positions of leadership and authority, or with specialized access to health knowledge. One of the responses that best summarized this sentiment was the following: "All of these people [are responsible]...its up to all the *bigman* [important people]."

Women: Organization and Solidarity

While women seemed, then, to view themselves as having a limited role and responsibility with regard to their health problems, there were many who, at the same time, said that one major barrier to change, to improvements in their lives as women, was their inability to join together and cooperate at the village level. One informant, when asked about how improvements to women's health might come about said, "I think it would be good if they [women] would come together into one place, to raise up the issues and express their thinking...their thinking must become unified."

Although many women felt that "joining together"³³ was an important prerequisite for improving their lives, all of them recognized that, although good in theory, it was much more difficult to achieve in reality. Of all of the women interviewed, only a very few said that they felt it was possible for the women in their village to join together in an effort to improve their health. The others all expressed doubt, saying it was very difficult and citing various reasons as to why this was the case. They identified, on the one hand, internal factors that related to relationships between women themselves, and, on the other hand, factors of

a more external nature that mitigated against women joining together.

There was, first of all, dissension and conflict at the level of women's organizations. There were two formal women's groups in the village: the PWMU (the "Presbyterian Women's Missionary Union") and the "Women's Club", which was originally a village-level branch of the National Council of Women, an organization established just after independence in 1980. Although there were a few women who were members of both groups, the two groups generally had an adversarial relationship, particularly at the leadership level, and a long history of conflict. Women of the PWMU complained that the club was a recent and unnecessary duplication, whereas the PWMU had had a valid role within the community for a long time. Some associated the club with the first political party in power, others complained that it had an "outside" origin and function, as opposed to being an authentic village organization. Club members, on the other hand, stressed that it was impossible to negotiate a working relationship with the PWMU because of some strong personalities in its leadership. While most women denied that the two groups were factioned along family or clan lines, the fact that the "Women's Club" had a name in the vernacular which matched that of a certain nakamal makes one wonder, given the loyalty that women feel towards their clan. Whatever the case, informants stressed that with women factioned in this way it was difficult to plan activities, organize for women as a whole, or get government assistance for projects (i.e. there was little communication between the two groups, sometimes a duplication of requests made to the government, and so forth).

Relationships between individual women appeared, almost always, to be characterized by friendliness, humor, and good will. With time, however, it became evident that there was little in the way of solidarity between village women and much in the way of underlying jealousy, distrust, and suspicion. One older informant claimed that this was the *fasin* (way or manner) from the past and that the situation had actually improved, since in days gone by women were hardly even comfortable venturing out of their homes to visit others. Another woman, also older, claimed the opposite. She said that the situation had worsened with time, in her opinion, because of *vatu* (money); families (and therefore women) were now much more competitive than they used to be. The following quotes illustrate the sorts of dynamics that informants identified as characterizing relationships between women:

Some women are O.K. but some aren't ... they can't join together with others to talk about work of any sort...like 'you're here but I don't like you, I'm here but you don't like me'

They just fight fight fight...

Its just all the women...they can't join together because there's all these small small groups, they're not in a good state because of this.

Informants spoke of the tendency of women to be competitive and jealous of one another, particularly with regard to the successes or innovations of others. One woman explained it this way: "I see that in this place, its a problem...like if one woman does something, the other one is jealous, its like she wanted to be the one to do it." The dynamics of competition and jealousy became evident to me early on in my role as a visitor in the village. Women commonly "compared notes", asking how many yams I had planted in the last person's garden (compared to theirs), if the lap-lap I was eating today was not much better than that I had been given on the previous day, and so forth. In fact, so much was jealousy recognized as an issue for women, that it was included as a workshop topic when the National Council of Women held their national festival in 1989 (VNCW 1990).

When women were asked if they confided in one another, they indicated that this was restricted to close family members, and that relationships with women outside their family, especially outside their clan, were characterized by distrust. One woman, when asked if she felt she could share her troubles with other women, replied:

No, there's no way...its no good. Like if I come to you, you won't be good to me because, and this is it now, I can't really talk to you, you'll be telling it all over again to others...if I have a problem, I can just go back to my family only, my mother, or my brother or my sister - that's it now.

Another woman similarly answered:

No, there's no way...I think a woman can tell it [a problem] to her husband, but to another woman, no way...its hard for her to tell another...because, you know, if she tells it, the woman will take it and tell it to someone else.

Some women felt that this tendency to gossip and resultant lack of trust was one of the main reasons women didn't join together:

...because if I go there, they talk about all the women. And after I've finished visiting with them, they'll get up and go talk about me over there...this habit in this place, it makes women reluctant to join together, to plan or discuss, like about health...that's how it is.

It was evident that for women and their families their primary loyalty was to their clan despite the fact that in

modern times clan divisions were often cross-cut by political-party allegiances or business-related disputes. There were many examples of how loyalty to clan was much stronger than any sense of solidarity between women themselves, but one case is particularly illustrative. One informant described, in detail, how her husband had once struck her on the ear (causing bleeding and temporary hearing impairment) because she had failed to cook on time. She talked about how she had run-away, back to her parents, leaving her small baby with her husband and in-laws. She told me, with some disgust, how his family had supported him in his action and that this was what made her particularly angry. I then asked her about another incident of battery with which I was familiar, a very severe case in which there had been scalp lacerations and a fractured forearm in a dispute over house-keys. In this case, the man who had inflicted the injuries on his wife was a first cousin of hers and considered to be part of her "family" (or clan). When I asked her what she thought about *this* case, she claimed that it was fundamentally different saying, "but her manner [that of her cousin's wife] is no good... she walks about [instead of staying at home]." "Yes, we supported him", she concluded. She could see only the differences between the two situations, rather than the commonalities that she shared with the other woman and she expressed little empathy for her cousin's wife. Her primary concern was to defend that action of her cousin.

Apart from the sorts of tensions that existed between women themselves, there were also factors outside of their relationship with one another that made joining together difficult. Some women said that given their workload, meeting with other women just wasn't a priority. As one woman stated, "They think about all their children, they think too much about the garden...so they can't join together well". Other informants stated that sometimes women didn't join in women's activities because of their husbands: "...some, they are thinking about their husbands, their husbands are blocking [obstructing] them, they are keeping them from joining together". When asked why it was that men would want to keep their wives from meeting with other women, informants had different hypotheses. As noted earlier, some men were said to be jealous of women expending too much time and energy on things unrelated to domestic upkeep and production. Some informants said that there were men who felt that certain women's groups were made up of certain factions of women and for this reason prohibited their wives from joining them. Others emphasized that there was no particular rationale involved, but that it was simply a matter of husbands exerting their authority and control. One informant explained that when women returned to their homes after attending a women's meeting, their husbands could be suspicious and cross:

[he accuses saying] "you guys were together talking

about this and this, weren't you?".....the women, they don't get a chance to explain anything at all,...they go back to their houses and they can get a beating.

Indeed, many informants emphasized that they had to make their interests and priorities secondary to those of their husbands:

If my husband tells me anything, I listen to him...it's like this: the man is the boss now, when he says to do something, you don't throw aside his instructions and follow your own thinking. You must follow his thinking first, then after, you do your own work. If you do like this, the two of you will be happy all the time.

For all of these reasons, "joining together" was not, for these women, something that occurred naturally or unproblematically. Relationships between women themselves, and external factors related to their roles and responsibilities as women made it difficult, despite the fact that most women felt it to be an important prerequisite for improving their lives and their health.

Footnotes

¹Not all of the women who take their produce to the market go every week; sometimes as few as three or four. But there are many who go from time to time, particularly when they are in need of some extra cash income.

²2000 vatu is the equivalent of about twenty Canadian dollars.

³The Bislama word "graon" (derived from the English word ground) is an important and commonly-used term. It refers to one's land (or, in other contexts, to soil or dirt).

⁴For more information see Ford (1993).

⁵By "recent", I mean within the last six months.

⁶For a more detailed discussion of health beliefs see section in this chapter on "Perceived Etiology of Health Problems". Also for a discussion of the *relationship* between western and indigenous practices see Ford (1993).

⁷The topic of *kastom* illness is covered more fully in the section on "Perceived Etiology of Illness" later on in this chapter.

⁸Of course these figures are crude in that they do not indicate how many times each women used each treatment alternative but they do illustrate the point that *holem bel* is a very common form of therapy.

⁹This is the treatment of what they felt to be "malaria" - these were not necessarily slide-positive cases.

¹⁰Since infertility is closely related to family planning, it has been included as a sub-topic under family planning.

¹¹In fact, she is referring to contraception, but interestingly the term commonly used in Vanuatu (and therefore learned by these women) is "family planning".

¹²At the time of writing this, there was not yet a national policy on the matter, although there was some movement in that direction.

¹³This is a commonly-used Bislama term meaning, in this context, to go out, to walk around.

¹⁴I did not conduct any formal interviews with men. This information was obtained by asking women what they thought the thinking of their husbands was.

¹⁵Although a trip to the hospital was not necessarily required for the husband (i.e. a woman might, for example, carry the consent form required for a tubal ligation for her husband to sign at home), it was not uncommon for men to accompany their wives to hospital in order to speak to the nurse or doctor, give their consent, sign the forms etc.

¹⁶In the past, the women had, as a group, been given a few health talks on family planning as a part of MCH services.

¹⁷One or two, however, had used oral contraceptives in the past and a few of the older women (now in their late forties or early fifties) had had depo-provera injections in the past.

¹⁸For a more detailed discussion, see Ford (1993).

¹⁹They worried, for example, about them getting lost, about forgetting to take them because their daily routines changed, about their husbands throwing them away because they were cross with them, about running out of them and having to get more. See Ford (1993).

²⁰There were also a few others who mentioned it, more generally, as a health concern for women.

²¹There were five with whom it wasn't possible to discuss the issue i.e. they didn't want to discuss it or, in a few cases, their husbands were present and we were not comfortable talking about it in their husbands' presence.

²²It is quite possible that the actual number is higher as there are many reasons for women to under-report on this matter (embarrassment, fear of reprisal etc).

²³The actual term used in the interviews was *kilim* which is a commonly-used Bislama word meaning to hit, beat, or strike.

²⁴*Kilim*, in Bislama, means to hit or to strike.

²⁵This Bislama word means to ruin or damage (derived from the English word "spoil").

²⁶This was the estimate given by the chief. My own observations concurred that there were not many.

²⁷Some villages on Malekula had already participated in this project wherein VIPs (ventilated improved pit latrines) or water-seal toilets had been constructed. The villagers provided the labour power, and the government (Environmental Health with the help of UNICEF) the technical help.

²⁸This is the Bislama term for health.

²⁹The researcher and the informants had to, again and again, clarify and arrive at a similar definition of health. For the purposes of this research health was taken to mean physical, mental, and social well-being, the definition of health in use at the time of the Alma-Ata declaration and still in use in many settings. It was easier to translate for the purposes of this study than the revised 1984 definition.

³⁰Some of these might be more appropriately classified as "supernatural" causes of illness as the mechanism by which the food exerted its effect was accorded some mystery, i.e. the involvement of the supernatural was implied. In other cases, it was assumed that some property inherent to the food itself caused the problem, i.e. a more natural cause.

³¹The three food groups were "body building, energy-giving, and sickness-blocking foods" (this was the classification used by Rural Health for health education).

³²The majority of the women interviewed (50 out of the 69, that is 73%) had only some primary schooling (in many cases only one or two years). Nine of the women had never attended school of any sort, seven had some secondary schooling, and three had attended courses at either a Bible college or a vocational school.

³³This is the English equivalent of the term *joen tugeta* which women themselves commonly used to describe the process of women coming together, cooperating, working toward a common objective etc.

CHAPTER 8

AN ANALYSIS OF THE FINDINGS IN RELATION TO PHC

In this chapter, the researcher returns to the four guiding questions delineated at the outset of the study: 1) Is improving health a goal or a priority for these women? 2) What health problems do these women experience in their everyday lives and what do they consider to be their priority health needs? 3) What health interventions do these women currently use and what sorts of etiological beliefs undergird them? and 4) How (through what or whom) are desired health changes to come about? Using these questions as a guide, the PHC model is compared with and reassessed in relation to the health perspective and circumstances of Nasilar women¹.

1) Improving Health as a Priority

According to the declaration of Alma Ata (WHO 1978, 46), the attainment of the highest possible level of health is "a most important social goal" and there is a need for "urgent action" to promote and protect the health of all the people of the world. Indeed, if PHC is to be perceived as relevant and to prove viable in any community setting, the attainment of health, more particularly the attainment of a higher level of health², is a value that must be shared locally. In other words, if a community has little interest in improving its health, the PHC approach is unlikely to be enthusiastically embraced.

It is clear from the findings of this study, that the highest priority for Nasilar women is gardening, and that on a day to day basis, protecting or improving their personal health³ is of secondary concern. In general, women accept the "wear and tear" that the hard work of gardening means for them as well as the time and energy it takes away from other activities. The study uncovered a number of reasons for this, one of the main ones being that it is primarily women themselves who shoulder the burden of caring for their many children; it is through *their* daily toil in the garden that their children are provided with food, and also with some of the *vatu* required for necessities of modern life such as school fees. Van Der Geest, Speckmann and Streefland (1991) have noted that in poor communities, it is often short-term gains, particularly monetary ones which displace longer-term health and development goals. Some people find that they simply cannot afford the long-term view, given the pressing nature of their more immediate survival needs.

In addition to meeting basic survival-related needs however, gardening was also found to help meet a much broader spectrum of needs for these women including that for self-expression, for self-esteem, and for social, cultural, and sexual identity. This broader role of gardening may be

of particular significance in contexts such as this one, where women are not provided with a wide variety of ways through which to meet basic social and psychological needs. In fact, it is through gardening, to some extent, that Nasilar women creatively cope with the social confines within which they live out their lives (not the least of which are its many patriarchal features). It is here that women can more fully exercise their powers of autonomy, their creativity, their industriousness. This, taken together with the role of gardening as a source of food and *vatu*, means that gardening has a powerful stronghold on the time, resources and motivation of women which health initiatives cannot really compete with.

There are those who might contend that given WHO's broad and holistic definition of health, gardening does indeed represent a concern with attaining or improving health (i.e. it represents an attempt to improve life physically and even socially). I would argue, however, that this is not the case: although the definition of health given by WHO is broad enough, fluid enough, and amiable enough to encompass almost any priorities that a community might identify⁴, it is possible to differentiate between this broad philosophical definition of health and "health" in its operationalized form in PHC documents. The latter becomes apparent if one considers the sort of objectives that these documents posit as basic to improved health (i.e. the eight elements) and the *means* that are identified as most appropriate for improving health (community participation etc). In other words, this information provides a picture of what the community moving towards health should look like: improved health will involve, amongst other things, community-based initiatives to provide health education, better nutrition, and adequate sanitation, none of which were a priority for Nasilar women. In this sense, the fit between the objective of "health", as WHO has operationalized it, and the sorts of objectives the guide the day to day life of these women is poor.

A second objection that might be raised against the assertion that Nasilar women are not very concerned about improving their health might be that adequate food supply production is one of the eight essential elements of PHC and that gardening therefore fits well with the PHC framework. Although it is true that Nasilar women's preoccupation with gardening represents a concern about adequate food production, this, as we have already seen, is only one of the broader spectrum of needs that gardening fulfills. And even were food production the *sole* reason for gardening (which it isn't), women's interest in improving *nutrition* (which corresponds more closely with the PHC model) remains very questionable⁵.

In summary, although these women were already heavily engaged in activities which might be considered health-related, they did not have the time, energy, or interest to make *improving* health, particularly as operationalized in PHC,

a goal or priority. What this finding illustrates is the extent to which those who have the most demands on their time and energy, who are the most work-weary, and have the least flexibility in their everyday roles and obligations, may find it difficult to participate in or even accommodate health innovations. It is interesting, in this regard, that Bensing (1984) has noted that it is often the well, as opposed to the sick or the weak, who most enthusiastically embrace PHC.

2) Health Problems and Health Priorities

This section focuses on the relationship between the eight elements of PHC (see Table 1 in Chapter 5), which the model designates as *essential* to improved health, and the health concerns articulated by Nasilar women⁶. In this regard, there are points of correspondence as well as divergence. Furthermore, when the health concerns of Nasilar women are closely examined, some underlying patterns become apparent. These patterns point to the relational nature of the health issues they identify and to the idea that the latter are, to a large extent, symptomatic of a much more fundamental underlying struggle.

Lack of Correspondence: PHC Elements of Little Concern to Nasilar Women

To begin with, some of the eight elements of the PHC model were of little concern to Nasilar women. For example, "prevention and control of locally endemic diseases", which would include, in this case, malaria, diarrhea, and respiratory tract infections, were not considered by informants to be priorities, relative to concerns of a more pressing nature. They apportioned little time or energy to village activities that could play a role in decreasing their prevalence (cutting grass and outdoor cleaning, for example, or improvements to hygiene) despite the fact that the value of such measures was understood. I have argued in a previous section, that "basic sanitation" was not a high priority in this village setting, despite the recent interest in the water-seal toilet project. And although, as just mentioned, food production was considered an important activity, the perceived importance of "proper nutrition" was more questionable.

With the exception of family planning, women were not very interested in "education concerning prevailing health problems". This was at least partially because of their workload (i.e. time and energy constraints) and the higher priority of gardening. But it might also be accounted for by their previous experience and consequent expectation of what "health education" might involve; sometimes it was directed to "problems" which women themselves did not see as being of high priority (nutrition for example). Or, if directed to

issues of concern to them, it was sometimes viewed, in the greater scope of things, as a relatively weak intervention. Several informants mentioned, for example, that on a few occasions family planning "talks" had been given to the women as part of MCH services. They emphasized that unless the health talks were also directed to men and some of the more fundamental barriers to family planning usage addressed, that this sort of health education was of very limited value.

Close Correspondence: PHC Elements Highly Valued by Nasilar Women

While Nasilar women demonstrated little interest in those PHC elements just mentioned, they highly valued "[western⁷] curative treatment for diseases and injuries" and "the provision of essential drugs". Indeed many spoke of these as pivotal to improved health. They did not commonly identify either of these as priorities for improvement or change however, probably because western medical services were already in place and well utilized. Taken together with traditional therapeutics such as *holem bel* and leaf medicine, a fairly broad and empirically sound⁸ array of therapeutics were already available. The same can be said of "Maternal and Child Health Care", more particularly the antenatal, intrapartum, and post-partum services provided at the nearby hospital (the issue of family planning is discussed separately below). These services were highly valued and already well utilized by Nasilar women. Again, taken together with *holem bel*, leaf medicine, and various taboos that formed the basis of traditional midwifery, women seemed to feel that health services related to child-bearing and child-care were already in place and adequate.

Apparent Correspondence: A Critical Examination of the Water Supply and Family Planning Issues

The eight elements of PHC and the health needs identified by Nasilar women appear to strongly correspond when it comes to the need for an improved water supply and for family planning. Women were particularly interested in obtaining more accurate information about the different types of family planning methods and concerned about the difficulties they had accessing them.

Although it is significant that within both frameworks water supply and family planning are identified as critical to improved health, to simply note that they appear on both "lists" is to fall short of examining the issues on a more critical level. That is, as one begins to appreciate the sorts of awarenesses and understandings that guided Nasilar women in identifying these as health priorities, it becomes apparent that the "match" between the two health paradigms is not so close as it might first appear.

While the Alma Ata document emphasizes a "safe" water supply, presumably meaning that which will not cause or contribute to disease, of paramount concern for Nasilar women was *accessibility*. It will be recalled that for many women in the study, the quality of the water was of secondary importance while lessening the distance they had to carry it, and thus their workload, was their primary concern. The water supply issue also embodied a deeper debate about whether or not women's workload was problematic; whether the work of women simply represented a natural division of labour or whether it was an issue requiring reassessment and change. As one informant commented on the water supply problem, "its like they [those who don't pay the monthly fee] don't think seriously about the hard work of women".

Similarly, when WHO documents speak of the importance of family planning, the *primary* emphasis seems to be on its medical-biological advantages; on how, by following certain reproductive advice, women can lessen their chances of having unhealthy infants or of having complications associated with pregnancy and childbirth. More specifically, a recent joint publication (UNICEF, UNESCO & WHO) emphasizes that childbearing between the ages of 18 and 35 years, spacing children by at least two years, and having less than five children has been shown scientifically to result in less perinatal morbidity and mortality. Although this is obviously of great importance to women, the findings of this study showed that medical concerns of this nature were not the main issue for these women. Rather, they were interested in family planning primarily because having fewer children would significantly reduce their workload and level of fatigue. More specifically, women felt that having too many children meant that they were chronically tired and weary, that they did not have the time, interest, or energy to make improvements to their lives or to join in women's formal activities, and that having to provide for many children meant that they were even more intensely involved in their gardening work⁹. Furthermore, several informants expressed the sentiment that having too many children was part of a larger picture of exploitation wherein women became chronically engaged in hard work while men retained a certain privilege and freedom. What these comments suggest is that these women were aware, on some level, that the family planning issue was part of a much larger arena of struggle, that their concern about the need to have some control over their reproductive functions was an expression of an underlying frustration with the maldistribution of work, of leisure, of advantage, and ultimately, of power. In this context, their comments on the importance of family planning surfaced as elements of contestation.

Although the tools of patriarchy are complex and vary from society to society, many feminists believe that patriarchal control is ultimately sustained through two material mechanisms: 1) control over women's labour power and women's limited access to important economic resources

and 2) women's restricted control over their own sexuality, more specifically over their reproductive functions (Brock-Utne, 1989). The latter (restricted reproductive control as a means of patriarchal control) may be of considerable importance in understanding and weaving together the many inter-related reasons that informants gave as to why they felt family planning was an important issue: while on one level, women's experiences of feeling wearied, depleted and detained by a heavy reproductive work burden simply represented the untoward effects of bearing and caring for many children, they were, on another level, important factors helping ensure that the social structure of the society, particularly that pertaining to gender relations, remained intact. When women are denied control over their reproductive functions and yet made almost entirely responsible for the reproductive process (i.e. bearing, caring for, and raising the children), they find themselves with a very limited amount of energy, time, and resources with which to involve themselves in activities unrelated to reproduction, much less to critically consider or contest the structures in place.

What the findings of this study have also elucidated is that even though women expressed strong sentiments about the importance of limiting family size, the family planning issue represented, for they themselves, a sphere of contention, contradiction, and struggle. This was evident in so far as women's frustrations with "overproduction" of children and consequent desire to limit family size were at least equally matched by a desire for sons in a society that was patrilocal, for daughters, given the traditional division of labour, with the need for the approval which one could acquire from the larger network of kin (including one's husband) by not deviating from reproductive norms, and by an ideology, reinforced by brideprice, that affirmed the role of women as bearers of children and producers of labour power. Wide-spread beliefs and fears about the dangers of modern contraceptives added strength to the arguments against family planning and compounded the issues.

Both the family planning and the water supply issues, then, represent, for Nasilar women, something beyond that of allowing women and their families to be "healthy" because they have clean water to drink or because they have less chance of medical complications associated with childbearing (these, of course, being good in themselves). They represent, it is contended, a struggle women are engaged in to affirm their basic value as persons and the legitimacy of their felt needs, this being a struggle of a much more fundamental and ultimately *relational* nature.

Beyond the Eight Elements: Health Problems and Priorities the PHC Model Fails to Address

There were, finally, some health problems which, while of central concern to Nasilar women, did not occupy a similarly prominent position amongst the eight elements of PHC¹⁰. Many women, for example, were troubled by musculo-skeletal problems, bachaches, and headaches which were directly related to their physical workload, that is to gardening and shelling-out copra, and to carrying heavy loads of garden produce, copra, firewood, and water. Although work-related injuries were seldom life-threatening, they were very common and played a very significant role in decreasing the quality of these women's lives. Furthermore, they were symptomatic of the fact that these women carried a heavier work burden than was optimum for their physical well-being. It is interesting, in this regard, that the ill-effects of over-work was a central theme that emerged when informants elaborated on the therapeutic value of some traditional health interventions. *Holem bel*, it will be recalled, was effective for a wide variety of symptoms from pelvic pain, to palpitations, to general malaise. But the underlying etiological explanation of its effectiveness had to do with the spleen "falling down" due to carrying heavy objects or undertaking heavy work. In effect, heavy work was an important factor rendering explicable quite a wide range of pathology.

Another important health issue that the eight elements of PHC did not address was domestic violence. On one level, domestic violence, more specifically wife-beating, was a health concern simply because of the direct physical and psychological trauma women (and indirectly their children) sustained from frequent and often severe beatings. Wife-beating, however, is also of importance because of the fear and self-blame it engenders and the way in which it thereby incapacitates. It is evident, in the Nasilar context, that wife-beating plays an important role as the ideologically-sanctioned use of overt force, ultimately helping ensure that women do not deviate from the roles and functions society has deemed appropriate for them. In this sense, its role is pivotal to many of the other health problems that women in the study identified; that is, challenging reproductive norms, workshares, or use of financial resources may all be perceived, on however conscious or unconscious a level, as potentially dangerous and therefore untenable courses of action. Some informants claimed that fear of husbands' jealousy and consequent reprisal (often violent) was one reason that women were reluctant to join in women's group activities. In so far then, as fear can incapacitate, domestic violence sets many limits on the activities and aspirations of women.

The fact that the women in this study identified some health needs that are not addressed by the eight elements of PHC does not constitute a very serious criticism of the

model, since the eight elements are said to be a *minimum* only and communities are expected to add to this list¹¹. When, however, the whole of the data concerning Nasilar women's health concerns are scanned, an interesting pattern emerges. It is this underlying pattern which leads one to conclude that the eight elements, taken together as the *core* of PHC, are not appropriately focused so as to cogently address the health needs of women.

On close examination, what becomes apparent is the extent to which many of these women's primary health concerns are directly or indirectly related to their domestic obligations, more particularly to their workload and to their reproductive responsibilities, and, to a large extent, to the subordinate position they occupy in a society which gives certain rights and privileges unequivocally to men. This linkage has been demonstrated in the case of "workload" related health problems (musculo-skeletal injuries etc.), in discussions around family planning and infertility, in the water-supply issue, and perhaps most obviously, in the issue of domestic violence. Furthermore, it would be grossly naive to assume that the sorts of gender-based roles and obligations which give rise to the health concerns these women identified could simply be changed at will; on the contrary, the roles, responsibilities, and obligations incumbent on these women are integral and, in some ways, even pivotal to the social and cultural fabric of the society¹². In this regard, it is not too surprising that the study findings highlighted a complicated assemblage of socio-cultural factors which mitigated against change in the lives of women. These included: the practice and role of brideprice which ensured that women were obliged (through both external pressure and internal motivation) to fulfill, rather than question, their marital responsibilities; a strong emphasis on clan loyalty and consequent lack of solidarity amongst women; traditional and religious ideologies that reinforced male dominance; taboos which reinforced female pollution beliefs and engendered fear with regard to the dangers of transgressing the current social order; and a lack of effective channels (traditional or modern) through which women could get redress for injustices.

It is important to address, before continuing, the legitimate concern expressed by many third world feminists that western-derived feminist constructs and meanings (such as "gender") are often applied to data in an overly-simplistic "blanket" manner, leading to reductive if not oppressive interpretations of other women's realities (Mohanty 1988, Goetz 1991). In this regard, some qualifications are in order. Firstly, although gender is being underlined here as a crucial factor in accounting for Nasilar women's health, the concept is being employed so as to highlight, rather than obscure, contextual and historical particularities; in the Nasilar context, it should be apparent that gender denotes a unique constellation of

factors relating to indigenous melanesian culture, colonial history, "Christian" religion, and class & race factors, all of which exert a determining influence on the nature of the relationship between women and men. Furthermore, as third world feminists have also stressed, the *relationship* between different aspects of these women's social location (particularly as regards class, race, ethnicity and gender) is necessarily a complicit and interdependent one: while, for example, gender has a particular class and ethnic character in this (or any) context, so ethnic and class categories are gendered (Anthias & Yuval-Davis 1983, Jolly 1991)¹³. The findings of this study have made it clear that the particular gender attributes characterizing Nasilar women are shaped and colored by their class position¹⁴, as well as by those other socio-cultural factors mentioned. Consider the heavy work burden Nasilar women carry: the general propensity to bestow on women a heavy work burden relates mostly (although not exclusively) to indigenously-based beliefs regarding the role and value of women blended with European misogyny (brought in colonialism and western religion). Yet the particular nature of this work (i.e. shelling out copra, selling vegetables as the only viable means of income) and the more general pressures that have come to bear on the community at large, making an income both necessary and difficult to attain, are closely related to class and race variables.

Gender then, as a crucial variable affecting Nasilar women's health, points to a unique and complex set of factors which determine the nature of the relationship between men and women. A second comment regarding the use of gender in this analysis relates to the idea that this study progressed in an inductive manner, and that it was, to a large extent, the discourse of informants themselves that validated the suitability of this construct. As noted earlier, informants themselves highlighted the maldistribution of work, leisure, advantage, and power between the sexes, thus circumscribing the idea of the *relationship* between men and women, not as an imposed analytical construct from without, but as part of their internal way of making sense of their life and their health (see chapter 7, "Perceived Etiology of Health Problems"). Grace Mera Molisa, one of the few Ni-Vanuatu women who has written from a feminist perspective suggests that Ni-Vanuatu women, because of the particularities of their Melanesian context and their colonial history, have little in common with their western feminist counterparts (Molisa 1978). But they still struggle with something she refers to as male-domination and in the post-colonial state, she explains, women have still to struggle to ensure that the issue of gender equality remains on the political agenda. The dismantling of colonialism does not necessarily mean for women the end of patriarchy or oppression; "Vanuatu is now free of foreign colonial domination" she says "but Ni-Vanuatu women are still colonized" (Molisa 1987, 2).

Furthermore, while some of her Pacific neighbors claim that the position of women traditionally, i.e. prior to European occupation, was equal or at least complimentary to men, Molissa believes that indigenous societies in Vanuatu were male-dominated (in Jolly 1991).

Having established that the construct of gender is a valid and enlightening tool for the purposes of this analysis, and having underlined that Nasilar women's health is intimately related to it, what can be said of PHC? While it may be true that PHC has come further than its health-policy forebearers in acknowledging the socio-structural basis of impaired health, it still fails, it must be concluded, to *adequately* situate health problems in the context of the power relations in which they are, particularly in the case of these women, so deeply rooted. For this reason, PHC and the eight elements it delineates represent a relatively superficial mode of health intervention.

Navarro (1984), in his critique of the Alma Ata Declaration, concludes that WHO documents, steeped in an environment of empiricism and atheoretical pragmatism, fail to analyze variables with adequate reference to their structural determinants and the power relations that give rise to them. Health problems then, become detached from their social roots and addressed as if whole entities in and of themselves. A close reading of the Alma Ata document shows that while the model claims to recognize the need for socio-political development, what it ultimately emphasizes is organizational and technological change within the framework of current power relations (Navarro, 1984). Take, for example, what is said with regard to women in PHC and the importance of support from the agricultural sector. Here, as Navarro (1984) points out, the document emphasizes that women are simultaneously involved in agriculture, household management, and the care of infants and children (WHO 1978, 46). It recommends, on this basis, that women need appropriate technology to lighten their workload and increase productivity, and education about nutrition, particularly as it pertains to pregnancy, lactation, and infant feeding. In this case, improvements to the life of women require more technology and more education but there is no mention of the need for a redefinition of gender relations; these are taken, rather, as a given. In contrast, some critics (Sidel and Sidel 1986; Zaidi 1988) have emphasized, and this study has concurred, that in order for the health of subordinate social groups, such as these women, to improve, social and political changes of a much more fundamental nature have to occur.

To the extent that the need for the transformation of social relations is marginalized from PHC discourse, the latter may inadvertently play a conservative role, helping to preserve and reinforce the current social order. And given that PHC philosophy is an accepted guide for health planning and discourse world-wide, it may also play an

important role in maintaining hegemony within the health sector.

3) The Context of Health Practice and Belief: A Comparison of Etiological Frameworks

It will be recalled that a wide range of therapeutic options, both traditional and western, were used by Nasilar women. These were, in turn, embedded in a complex system of belief regarding the causation of health problems which minimally included factors which the researcher classified as natural, supernatural, and socio-economic. Beliefs in natural causes of ill-health were reflected in the use of some home remedies and in the use of western medicines. Supernatural etiological factors rendered viable leaf-medicine and counter-sorcery techniques (such as *sing-sing* or use of *kleva*). Socio-economic factors gave meaning to the importance of income-generating activities and certain aspects of social conduct such as obedience to one's husband so as to minimize conflict in the home.

Although the etiological framework underlying the PHC model is seldom made explicit, it is not difficult to deduce from the sorts of interventions the model recommends for improving health. What the PHC model basically recommends is 1) administrative, fiscal, and organizational changes so as to make community-level care the priority, 2) the use of relatively simple, low-cost but effective health resources and technology (education about common diseases, basic medicines, sanitation, immunizations etc) and 3) community self-reliance in initiating and sustaining local level health care. These recommendations are based on primarily two sets of etiological belief. Firstly, there is the bio-medical understanding of health problems on which the need for immunizations, sanitation, and almost all of the eight elements of PHC are based. Secondly, the model recognizes the broader economic causes of poor health in so far as it speaks of the need to reallocate scarce resources within and between nations so that the health of those in the periphery can be improved. The emphasis on the need for community participation and self-reliance is likewise based, at least in part, on the realization that given the economic and political context of many communities, it will be difficult to improve health otherwise.

When these two frameworks of etiological belief and corresponding modes of intervention are interfaced, some interesting issues emerge. Firstly, in the PHC paradigm, supernatural, or even metaphysical factors in illness causation are conspicuously missing. In contrast, informants in this study commonly accounted for health deviations in the context of a much broader social, spiritual, and moral dimension; lack of respect for *Aastom*, transgressing a taboo, angering a neighbor (and their consequent use of sorcery), or failing to adhere to

religious faith could all eventuate in health problems. As Matimbwiwa states, in traditional societies, health is almost always viewed from a religio-physical angle: "Religious beliefs, including concepts of health, disease causation, human growth and development and hereafter are all intricately interwoven into a comprehensive approach to health" (1989, 928).

On the other hand, PHC and the health innovations it recommends have evolved in the context of the dominant western medical discourse, which being, in turn, rooted in empiricism and the naturalistic scientific model, has tended to separate the metaphysical from the physical. In this sense, it differs fundamentally from the indigenous health framework and as such runs the risk of being recognized as far less than the comprehensive approach to health problems that it claims to be. In fairness, because the methods and interventions the model recommends are stated to be a *minimum* only, it cannot be said that PHC negates this broader etioloical dimension, and indeed some of the PHC literature has focused on engaging traditional healers in PHC endeavors (which would imply affirming indigenous beliefs and practices to some extent¹⁵). Yet in its operationalized form, PHC is obviously strongly skewed to favor health interventions based on the bio-medical causes of ill-health. When informants spoke of the value of western health interventions, they sometimes made qualifications such as "if its a straight-forward kind of sickness" or "if its a good kind of sickness", indicating their awareness that some types of illness and some dimensions of ill-health were beyond the scope of western medicine and likewise beyond models and remedies for health problems that derived from the western world. They were acutely aware that the latter covered only part of what was, for them, a much broader spectrum of ill-health causation.

The issue of supernatural ill-health causation also links back to a central theme of this analysis, that being the significance of the socio-cultural context, more specifically gender relations, to women's health problems. A close examination of indigenous beliefs regarding ill-health reveals that many of these beliefs play a role in stabilizing the current social order and thereby in preventing change as regards roles and mores of women. This is so to the extent that it is often social conflict or a failure of social conduct (i.e. failing to keep a proper distance from one's in-laws or failing to avoid contact with men during one's monthly period) that is said to be the original source of an illness. The overall effect must be to engender fear in both women and men with regard to transgressing or even questioning traditional social norms. What all of this means for PHC is not only that the model fails to cover broader supernatural factors in ill-health causation, as argued above, but again, that it is somewhat naive to the integrated and complicit forces which mitigate against change in the lives of women.

This leads us to consider a second gap between the two etiological frameworks, one which reflects and embodies much of what has already been said about the weakness of the PHC model. It will be recalled that informants *themselves* identified every-day social relationships, particularly those relating to gender, as etiological factors having an important influence on health status: if, for example, your husband helped you in the garden, you were not too work-weary or if you were beaten frequently you could not look after yourself or the children well. Although PHC documents do acknowledge "social development" and "economic development" as closely related to health improvements (WHO 1978, 44), they do not identify or address the issue of gender relations as a key factor effecting health status. While the PHC model identifies MCH as an essential component of health care, thus recognizing women's unique *biological* needs, the topic of gender relations, which would encompass the broader issue of the impact of *socially* constructed roles and mores on women's health, is absent.

4) How Health Changes Come About; The Role of Self Reliance and Self Determination

Community participation, self-reliance, and self-determination are central to the PHC model and considered essential if the goal of "health for all" is to be achieved. Communities, sub-groups within them, and individuals are expected to increase their autonomy, and to take an active role in diagnosing priority health problems and planning interventions to alleviate them. As already mentioned, this emphasis is said to rest partly on the pragmatic realization that given the economic and political climate of many countries, health is unlikely to improve otherwise. But it is also based on moral imperatives concerning the right and duty of individuals to take more responsibility for their health and to exert a greater control over their destiny.

In contrast, when Nasilar women spoke of improving their health, they did not emphasize notions of increased autonomy. Rather, they felt it more appropriate for health interventions to be initiated and implemented by outside authorities in a top-down manner. The government, the rural health service, the chief, in short the *bigman*, ought to take responsibility. Women seemed to feel that they lacked the necessary knowledge and resources to initiate and implement change and they were skeptical about their ability to work together at the community level. They had an obligation to listen and cooperate, they conceded, but not to initiate, much less to assume responsibility.

Many explanations might be brought forward to account for the passive orientation of these women in health matters, or what some might refer to as an "external locus of control". These would include their previous experiences within the health department which, despite appearances, has often operated using a "top-down" approach, the "cargo-cult"

mentality¹⁶ which assumes that goods and services can and should come from without, and women's lack of certain types of social and political decision-making experience, being traditionally excluded from the sphere of the Nakamal. What *this* study would highlight is the context of gender relations in which many of these women's health problems are rooted and the extent to which the notion of Nasilar women as self-determining agents of change represents a naive, idealistic, and ultimately foreign conception. How, for example, can Nasilar women implement family planning if they do not ultimately possess the decision-making power on such matters? How are they to take the initiative with regard to domestic violence when it is sanctioned at the community level and supported by in-laws and relatives? How can the water supply situation be improved and maintained if they don't control the *vatu* required for monthly payments? How can they even join together to initiate health changes if the social structures and ideologies in place impede unity amongst women, when their workload prohibits spending time in women's groups, and when, in many cases, their husbands look unfavorably on it? It should not be too surprising that the idea of women taking ultimate responsibility for their health met with a less than enthusiastic response.

While women are not in a position to simply "take hold" and change those factors which affect their health, this is not to paint them as utterly powerless either. Indeed, Nasilar women demonstrated remarkable strength, initiative, and resourcefulness within the socio-structural confines of their lives. Consider, for example, the fervor with which they gardened, to a large extent because they knew it was essential to the survival of their children. Furthermore, glimmers of resistance, that is challenges to or subversions of the ideologies and structures in place surfaced from time to time: consider a few of the younger women who were choosing to remain single even though they had children; the willingness of many women to ask detailed questions about contraceptive methods despite the fact that this has traditionally been a forbidden topic; women's discussions on domestic violence and its contradictions wherein they ascribed to the ideology that justified it and yet expressed resentment and anger about its effects in their lives; even their ability to say "no" to some organized women's activities, which while on one hand may have worked against solidarity amongst women, also showed that they had already evaluated them as time-wasting and of little use. It is not then, as if Nasilar women *never* question or challenge the socio-cultural context of their lives. And change may well be forth-coming, particularly as more indigenously-based mobilizing and empowering processes become available to Pacific women. The essential point for this analysis however, is that one should not underestimate the multiplicity and complicity of gender-related factors that mitigate against change in these women's everyday lives and which limit the extent to which they can manipulate

their health status outside of far more profound and comprehensive changes to their social context. The PHC model advocates community participation and self-determination as the new vehicles for improving health as if they are simply a matter of will, effort, and organization. Yet for women, who represent a large portion of this community, the model seems inappropriate and unrealistic because there are too many issues, of a socio-cultural nature, which must first be addressed.

Van Der Geest, Speckmann, and Streefland (1991) suggest that people may "rightly gain the idea that highlighting self-reliance is a euphemism for leaving them to fend for themselves". Although they make this comment with reference to the economic context of health, the same can be said of women in such a socio-cultural context. The PHC emphasis may amount to asking women to take charge and change their health situation in a context which, because of the structures in place, makes this an emotionally and socially untenable task. This, it is contended, amounts to asking them to swim upstream in a fast-flowing river without acknowledging, or equipping them to deal with, the strength of the current.

Conclusion

In this chapter, the researcher has examined the "fit" between the health perspective of Nasilar women and the PHC model. Although some points of correspondence have been identified (i.e the need for education about family planning methods, the importance of the availability of western curative services) what have become most obvious are the ways in which the two frameworks diverge. The finding that improving health is not a priority for Nasilar women, that some health issues, which are of key importance to Nasilar women, are not addressed by the PHC model, and that Nasilar women understand ill-health causation in a way that differs significantly from that on which the PHC model is premised all cast doubt on the viability of the PHC model in this context. A more serious problem, which the study findings have also highlighted, has to do with the extent to which the health problems faced by Nasilar women are rooted in and inseparable from socio-cultural factors which relate to their subordinate social position. Because PHC leaves unchallenged the power relations in which women's health problems are situated and addresses only certain practical needs of relevance to women, it cannot legitimately claim to be the means through which "health for all" will be achieved. Hence, although the model is undoubtedly of some practical value for women, it must be charged as misguided in its claims.

The PHC model is based on some questionable assumptions, a main one being that people are quite free to act as self-determining agents of change. It is true that the model does not naively assume that everyone is equal, and speaks of the need to redistribute health resources and of the need to give extra help and support to "vulnerable" groups (WHO 1978, 26). But even these concessions betray an underlying conception of communities as collaborative, embracing values of fairness and equality, quite willing to make the necessary changes to improve the health of the marginalized and oppressed. Indeed, the definition of "community" that the Alma Ata document offers emphasizes shared aspirations and interests¹⁷. An alternate conception of community life might emphasize that communities are sets of power relations, that there are conflicts of interest, and that seriously undertaking to improve the health of subordinate groups will not only threaten the privileges of those in positions of relative dominance, but threaten to undermine the structure of society itself. As this study has underlined, differential power relations, positions of dominance and subordination, are not merely superimposed on the social and cultural fabric of society; they are more often integral to it.

The first conclusion of this study then, is that PHC represents a relatively weak model for improving women's health and is therefore unlikely to be the vehicle through which "health for all" will be achieved. A second contention, based on the theory of ideology, is that PHC, to the extent that it makes social transformation a tangential rather than central concern, plays a role in preserving the current social order and in reinforcing the interests of dominant social groups. This is not, of course, the result of some sort of conscious deliberation or scheming on the part of health philosophers and planners but rather a natural effect of the relationship between social structure and the development of human thought: dominant knowledge systems and conceptual models, simply by virtue of the ways in which they frame problems and through the concepts and definitions they provide (or don't provide), focus and limit our understanding in ways that are generally synchronous with the larger social context of our lives. More specifically, the dominant health paradigm, in which PHC gestated, is one which marginalizes the important effect of social structure on health, one which seeks to improve health without seriously challenging its larger social context. What has become obvious from this study is that PHC is *not* a philosophy grounded in the experience, life-context, or understanding of Nasilar women.

Hegemony, applied to health planners and professionals, would refer to a state in which the latter possess a consciousness so saturated with structures and forms rooted in underlying social relations, that they are unable to understand and interpret health problems in ways that are truly alternate. The danger is not so much that we

don't dare to think in alternate ways as that we *forget* to. The value of ethnographies such as this one are that they enable us to enter, for some time, the ontological and epistemological frameworks of others, as well as the existential context of their lives, so that the cracks, fissures, and contradictions of our own health "gospels" become visible and amenable to criticism.

Implications for the Future

This analysis has underlined the idea that social context, more particular gender relations, play a fundamental role in determining the health status of women. In terms of future planning, what has become obvious is that unless health models and programs begin to more seriously address factors that relate to the social position of women, not merely their health condition, their health profile may well remain much the same.

This means that beyond addressing the practical health needs of women (the need for antenatal services, for example, or the need more education about nutrition), which are good in themselves, considerable emphasis must be placed on what has sometimes been called their *strategic* needs, that is on longer-term objectives which focus on such things as reducing their vulnerability to violence and exploitation, a more equitable sharing (with men) of responsibility for reproductive work, more economic security, options, and opportunities, and the development of greater solidarity with other women for strength and for action. (CCIC, MATCH & ACOCI 1991; Moser 1991). The particular form these sorts of objectives will take is, of course, a complex and context-dependent matter; in the Nasilar context, it might mean the health sector taking a more active role in challenging certain traditional practices as they pertain to women's health, for example encouraging the churches and the national council of chiefs to publically clarify their stands on issues such as wife-beating and brideprice. At the very least it means that interventions designed to bring gender inequalities into the public eye and to support the empowerment of women must be no longer seen as tangential or merely supportive of the work of the health sector, but essential and integral to it. For example, any programs or interventions designed to improve women's "health" should be carefully evaluated as to the effect they have on women's social position and as to their potential for empowering women to take greater control over their lives. This is important since health programs can and have at times, often quite innocently, played a part in reinforcing restrictive roles for women; consider, for example, Nasilar women having learned, through the activities of the rural health department, to equate *helt* with women learning to clean up well.

As for the PHC model itself, there are those who would suggest that the latter encompasses, or at least leaves room for this sort of an emphasis since the Alma Ata declaration does underline the idea that inequalities in health status are unacceptable and should be challenged. Furthermore, more recent discussions in some of the WHO literature around the concept of equity have called attention to some of the avoidable and unjust differences in health status between different subgroups of populations (Whitehead 1991). While they still tend to emphasize welfare measures as the main solution, rather than the need to challenge the social structure of society¹⁸, they do indicate that the effect of community-level¹⁹ social inequities on health is beginning to receive more serious attention. Likewise some of the recommendations resulting from the 1992 World Health Assembly's technical discussions on "Women, Health, and Development" (WHO 1993) begin to encompass some of the more "strategic" objectives emphasized here. Whether or not the PHC model can ever be reoriented so as to make social transformation a serious operational objective, and still remain "PHC", remains to be seen. An even more interesting question is whether or not, in this case, it would enjoy the same sort of popularity as it has to date.

Directions for Further Research

While this study has been very useful in illuminating the linkages between health and the roles, mores, and obligations of women, it has also been somewhat unidimensional, pointing to, but leaving largely unexamined, the ways in which other social variables (i.e. class, race, ethnicity) intersect with gender attributes and thereby shape women's health. Some of the main health topics that emerged from this study would benefit from a much more detailed, multi-faceted analysis. Domestic violence, for example, although rendered meaningful in the context of gender, would benefit from close examination focusing on ethnicity and class as well. How, for example, do Melanesian understandings and expressions relating to conflict and conflict resolution shed light on this phenomenon? Or, how does class, more specifically the effects of poverty or urban drift, affect it? Likewise, the family planning issue is shaped by social variables that can be recognized as distinct from (although intersecting with) gender. Class factors, for example the grass-roots antipathy to population policies and hence family planning, need to be explored. In effect, the sketch that has resulted from this study, while underlining some important linkages between women's health and its social context, needs to be extended, colored, and filled in so that it becomes more sophisticated, less reductive, and therefore more useful in a political and practical way.

A second major area for research is of a much more practical nature. While studies such as this one *elucidate* the

relationship between women's health and its social context, there is a need to develop viable health education approaches and strategies which help empower women (and men) themselves to explore and articulate the linkages between the everyday social context of their lives and their health. Despite the emphasis in some of the health promotion literature on "healthy environments" (Epp 1986, Glynn & Edwards 1988), health education messages, in many settings, continue to be oriented to bio-medical illness causation and to assume individual behavior change to be the end goal. These approaches, which are often prescriptive, didactic, and paternalistic, might be replaced by those that point to the *interrelationships* between different spheres of life, encouraging people to explore these and develop more integrated and creative solutions to their health problems. Several years ago, in the context of literacy education, Friere underlined the need for a "problem-posing" education; one which would take the concrete reality of the learner as the starting point and affirm individuals as aware beings, limited in their cultural and historical participation by oppressive structures (Friere 1970). This has enormous application within the health education field, particularly as regards education for women and women's health.

Footnotes

¹The reader is referred back to Table 1, Chapter 5.

²While it may be universally true that people value their health, *improving* their health or attaining a *higher level* of health may not be a priority.

³Here I am using the definition of health found in the 1978 PHC document wherein health is said to be a "state of complete physical, mental, and social well-being", since this is the definition I used during my fieldwork. I realize that the definition has been since modified so that health refers to a capacity or resource for daily living so that one can realize aspirations or, on the other hand, change the environment. Even were the more recent definition used, however, the same point holds: Nasilar women did not have the time or energy to make *improving* their ability to cope with or change their life a priority. They were simply coping, maintaining the status quo.

⁴In this sense, one wonders if, at some point, the analytical usefulness of this new definition becomes questionable; one might argue, for example, that almost anything an individual views as helping him or her to cope with her environment can be seen as adding to her "health".

⁵See chapter 7, section entitled "Health as a Priority for Women."

⁶It is fair to contend that this comparison is unfair since PHC was never intended to specifically address women's health problems. However, in so far as women represent a high proportion of the community, it is relevant to ask about the extent to which PHC addresses their health problems.

⁷ I say "western" because when the document specifies *appropriate* treatment, it means, amongst other things, appropriate as verified by modern science (WHO 1978, 59)

⁸They may not have been *scientifically* sound, but they were verified as useful and effective on the basis of experience and tradition.

⁹The reader is referred back to chapter 7, section within "Family Planning" entitled "Motivating Factors".

¹⁰It is true that the eight elements, and certainly the PHC framework in general, can *encompass* them. For example, the first essential element of PHC is education regarding prevention and control of prevailing health problems. Also the last component includes treatment of common injuries

which would encompass work-related health problems. But what the model is comprehensive enough to accommodate and what it emphasizes are two different matters.

¹¹Another issue that could be addressed at this point is whether or not domestic violence is likely to be identified as a health priority in a community such as this one. I'd suggest it is highly unlikely.

¹²For example, consider, as noted in chapter 7, the important role of women in kinship transactions via brideprice.

¹³For example, the category of "class", in any given context, will embody and reflect certain gender proportions and relations (i.e. women being overly represented in low-income groups). Likewise a given ethnicity will reflect, and to some extent be characterized by, certain gender relations and attributes.

¹⁴Here "class" would refer to their position in the national and global economic order.

¹⁵I am unsure as to what extent this would be the case since the Alma Ata document states that methods and technologies must be scientifically sound.

¹⁶In Vanuatu, there are still some real cargo-cults in existence (cults which immortalize certain world-war two figures and believe they will return bringing cargo, goods, etc. as they did before). Some people feel that this mentality of dependence on outside western goods is characteristic throughout Vanuatu, based, to a large extent, on the reality that aid dollars per capita in Vanuatu are among the highest in the world. Not only is outside aid essential to most development projects and programs but it has a high profile as well.

¹⁷It reads as follows:

A community consists of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social, and cultural characteristics, as well as interests and aspirations, including health. Communities vary widely in size and socio-economic profile, ranging from clusters of isolated homesteads to more organized villages, towns and city districts (WHO 1978, 50).

¹⁸For example, Whitehead (1991) emphasizes such measures as improved housing and improved water supply for improving the health of those in the lower socio-economic groups; the need to challenge the larger socio-structural context of society which, some would contend, lies at the base of these injustices, is not included in the discussion.

¹⁹The original PHC declaration, while speaking of health inequalities both between and within populations, tends to emphasize the former; it mentions several times the gap between the health status of those in "developing" and "developed" countries but says little about social inequities at the community level.

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APPENDIX 1

INTERVIEW GUIDE (English Translation)A) General Background Information

- 1) age.....
- 2) village/island of origin.....
- 3) marital status.....
 - a) single.....
 - b) married (specify custom or church or both)....
 - c) cohabiting.....
 - d) separated or divorced.....
- 4) number of household occupants.....
- 5) number of children.....
ages of last two children.....
- 6) educational level attained (specify primary, secondary, tertiary).....
- 7) literacy:

can speak:	Bislama....	English....	French....
read :	Bislama....	English....	French....
write:	Bislama....	English....	French....
understand:	Bislama....	English....	French....

B) Health as a Priority for Women

- 1) How is the life of women here.....do you feel that everything is alright?.... Do you feel that there are any things that need to change?
- 2) How do you think the physical health of most women is? Are most women well? Are there some problems or sicknesses that are afflicting women?
- 3) What kinds of things, in the lives of you as women, cause you concern or worry? Are you concerned or worried about your health? Are there other things that concern you more?

C) Personal Health Status and Practices

- 1) How is your health right now? Are there any problems or concerns that you have; is there anything that you are worrying about?

general health.... abdomen (G.I.)....musculo-skeletal....

head and neck..... urinary..... skin.....

chest (cardio-resp)..... reproductive.....

- 2) Have you ever stayed overnight in the hospital (other than to have a baby?) When & because of what?
- 3) If you think of last year, that is from the beginning of 1991 up until the present time, have you gone to the hospital because of sickness or some other health concern? How many times did you go and for what reason ?

During the same time did you see a kleva? How many times and for what reason?

During the same time did you use a custom leaf for some health problem? How many times and for what reason ?

During that time did you seek someone out to *holem bel*? How many times and for what reasons?

During the same time, did you have the pastor or elders come and pray for you because of a health problem ?

During that same time, did you go and see any other kind of healer because of a health problem? Who did you see? How many times? For what reason ?

D) Health Priorities and Health Changes

- 1) I have spoken with alot of women and there are alot of different ideas they have about how the health of women should be improved. Some say they need to learn more about cooking nutritrious food, some say they must make toilets, others...use family planning, get a better water supply, try and stop wife-beating, get rid of malaria, get rid of coughs, clean the house and village better and so on and so on. What is your thinking on the matter ? Do you side with one of these women or do you have a different idea?
- 2) What do you think keeps the health of women from improving more? What kinds of things block it?
- 3) How do you think the health of women can be improved? What needs to happen?

- 4) From your point of view, who is responsible for improving the health of women here? (for example, the hospital staff, women themselves, women's husbands, the whole village, the government...what is your thinking?)
- 5) Do you think that all of the women in Nasilar could join together to try and make the health of women improve?
- 6) If a nurse was coming and was going to give a health talk, what topic would you like her to cover?

E) Reproductive History and Present Practices

- 1) history: gravida.... parity.....
present number of living children.....
adopted children.....
- 2) Do you think you'd like to have more children ?.....
Have you ever used any kind of family planning?.....
If so, what kind?..... Did you like it? Did you find it to be effective ? (If has never used family planning, how does she feel about it? i.e. wants to, is afraid, doesn't believe in it, etc.)

Have you ever used a custom leaf as a contraceptive?
How did you find it? (Did you like it? Did you find it to be effective?)

Do you use any other method to space or prevent pregnancies? (i.e. abstinence, calender method, coitus interruptus?)

F) Domestic Violence

- 1) I know that it is not uncommon for men to beat their wives from time to time. What is your thinking on the matter? Do you feel this is a big problem in the life of women here, or more of a minor matter?
- 2) Does your husband beat you sometimes? Has he beaten you during this year already (1992)? What about last year?....
- 3) Do you think that a man has the right to beat his wife? (if "yes" why does he have the right? If no, why is it improper for him to do so?)
- 4) (if responds "no" to #3) Do you think that this is something that can be changed ? How? (Why is it hard to change?)